WEST REGION EMS & TRAUMA CARE SYSTEM PLAN

July 2005- June 2007

Submitted By: West Region EMS & Trauma Care Council

To: Washington State Department of Health

Date: May 13, 2005

EMERGENCY MEDICAL SERVICES & TRAUMA CARE SYSTEM
FY 06-07
WEST REGION
BIENNIAL PLAN

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I. Executive Summary

The West Region Trauma System Plan seeks to create a model system that effectively reduces injuries and fatalities as well as treats and rehabilitates trauma victims. The mission is to reduce human suffering and costs associated with morbidity and mortality. This is accomplished through providing assistance and guidance to local providers in the coordination and improvement of EMS and trauma care services.

A fully functional trauma system addresses education, prevention, rapid communications, prehospital care, in-patient trauma care, rehabilitation, a trauma registry and a quality assurance/improvement program. To guarantee all citizens and visitors appropriate and timely EMS and trauma care, the West Region focuses its efforts toward prevention education and medical training of EMS and trauma personnel, trauma level designations of hospitals, trauma verification of prehospital agencies, improved data collection, and regional quality evaluation and improvement.

Needs, goals, objectives, strategies and potential barriers are determined based on identifying resources, conducting needs assessments, and ongoing discussions at the Council's standing committee meetings. Annual review and evaluation of the West Region Trauma Plan is conducted by the standing committees as well as by the full Council.

Major regional needs and goals for the upcoming two years are described below. These goals do not replace other important work being done through the state emergency medical and trauma prevention system. However, they highlight areas where significant progress, accomplishments and opportunities demand the Council's attention and involvement.

Regional System Coordination
The West Region Council enjoys an active and dedicated membership which accomplishes comprehensive EMS and trauma care planning through committee structure. Needs of the Council include ongoing recruitment and orientation of new members and the annual review and development of Council bylaws, budget and goals.

Injury Prevention & Public Information/Education
The regional prevention program is overseen by the volunteer membership of the West Region Injury Prevention and Public Education Committee and is staffed by a coordinator from the West Region office. Data shows the top three injury prevention concerns of the region are falls, motor vehicle crashes and suicide; injury prevention programs in the West Region are driven by the needs of the population which is suffering from these specific fatal and non-fatal injuries.

Prehospital – Communication

Communications systems continue to function on a regular basis in the region; however there is concern over how multiple patient, mass casualty, or other disaster incidents will strain systems in place. This issue has begun to be addressed through efforts between Homeland Security Region 3 and the Hospital Emergency Preparedness & Response Program of DOH.

Prehospital – Medical Direction

The four Medical Program Directors (MPDs) within the West Region are a leadership resource and essential link between prehospital and hospital care within each of their counties by providing medical off-line and on-line direction. The MPD functions as a liaison between each of the counties and the regional structure; there is a need to keep the MPDs actively involved in regional activities.

Prehospital – EMS & Trauma Services

Recruitment and retention of first responders has seen a decrease in the past two years; retention could be helped if training was paid for to maintain certification. The West Region Council provides 23% of its annual contractual funds to prehospital training. The Council maintains contracts with each of the county EMS Councils and Centralia Community College to deliver training to providers. However, these funds do not adequately cover the training expenses of the region needed to help retention. The Council also responds to the region wide need for a stable SEI and instructor pool by providing funding and education.

Prehospital – Aid & Ambulance Services

The need for funding resources at the local as well as regional level continues to be an issue. Agencies attempting to comply with present state mandates in order to maintain verified status are often without the funds to do so. The regional council has occasional, but not steady opportunities to seek funding to pass through to individual agencies or departments, depending on the need.

Prehospital – Patient Care Procedures

Annual review of the regional prehospital Patient Care Procedures (PCPs) is the responsibility of the four Medical Program Directors and the Council. There are currently no changes to the PCPs.

Designated Trauma Care Services

There are 13 designated trauma care services currently operating within the West Region. There is a need for introductory as well as ongoing training of emergency department, ICU and critical care nurses in the region. The regional office provides administrative support to the West Region Emergency Nursing Education Cooperative which has developed a program to train nurses interested in clinical practice in the emergency department. Additionally, the region annually sponsors WAC-required trauma education for facilities within the region.

EMS & Trauma System Evaluation

The West Region will continue to work with the DOH to develop a much needed statewide data collection system which will assist with system evaluation. The regional Council and staff will also continue to provide administrative support and participation in the West Region Quality Improvement Forum (QIF). The current configuration of the QIF works well for all participating facilities and the region chooses to continue its affiliation. Under the leadership of the designated trauma services, the QIF coordinates trauma case study/education, develops and reviews data, and shares confidential, critical information to optimize trauma and EMS care and outcome throughout the regional system.

All Hazards Preparedness

The West Region Council will continue its participation in Homeland Security Region 3 hospital and prehospital activities as determined by the DOH Hospital Emergency Preparedness & Response Program. The Council collaborates with Thurston County Public Health to accomplish deliverables as outlined in CDC and HRSA grants for Region 3.

REGIONAL PLAN GOALS

- *Council membership recruitment and orientation is reviewed and updated by the West Region Council and staff.*
- *The West Region EMS Council goals, budget and by-laws are annually reviewed.*
- *Roles and responsibilities for production of the biennial EMS & trauma plan are reviewed and developed by the West Region EMS Council.*
- *System costs are identified for the goals, objectives and strategies of the 2005-07 West Region Trauma Plan.*
- *Reduce death and disability due to injuries in the West Region through activities and awareness.*
- *An effective West Region communications system.*
- *County MPDs fully participate in the regional EMS & trauma care system.*
- *The needs of the OTEP and CME within the West Region are supported by the Regional Council.*
- *The West Region has a stable SEI and instructor pool.*
- *Special funding sources are available to assist West Region agencies or departments in need*.
- *The Regional Patient Care Procedures support optimal care of the trauma patient.*
- *The number of trained emergency department, ICU and critical care nurses meets designated trauma care service needs in the West Region.*
- *The West Region uses electronic data collection and information systems that link prehospital, hospital and dispatch.*
- *EMS and trauma system evaluation is overseen at the regional level by the West Region Quality Improvement Forum.*
- *Prehospital and hospital quality assurance/improvement training is supported by the Regional Council.*
- *Prehospital all hazard preparedness needs are identified.*
- *Hospital all hazard preparedness needs are addressed.*

THERE ARE NO PROPOSED PLAN CHANGES REQUIRING DEPARTMENT APPROVAL

II. Authority – Regional System Coordination

System Status - West Region:

The West Region EMS & Trauma Care Council is empowered by legislative authority (RCW 70.168.010-70.168.900) and Department of Health Administrative Code (WAC 246.976) to plan, develop, and administer the EMS and trauma care system in the five counties that make up the Region. It is one of eight regional councils statewide composed of local providers and consumer representatives, funded primarily by the Washington State Department of Health (DOH).

The West Region is a major population, manufacturing, transportation, and shipping corridor as well as tourist center of the state (second only in these areas to the single-county Central Region). Its jurisdictional composition is a five-county area including Grays Harbor, Lewis, North Pacific, Pierce and Thurston Counties. The large urban and rural geography spreads population density centers out and increases the challenge for emergency medical service (EMS) response and treatment services in an area of over 7,000 square miles.

The West Region population continues to grow at a rapid rate, ever challenging the regional EMS and trauma care system to provide timely and effective service. Intermediate projections by the Washington State Office of Financial Management show a regional population increase between 2000-2005 from 1,064,953 to 1,469,607. These service challenges stress the regional resources for response, treatment and financial capabilities. An increase in population also increases the demand for rapid, quality services. These needs are in contrast to increasingly elusive funding resources to support public health and safety.

The West Region EMS & Trauma Care Council accomplishes comprehensive planning through a committee structure with final approval by the Council. Fifty-one Council positions represent local healthcare providers, local government agencies, and consumers from areas as metropolitan as Tacoma and as remote as the rainforest on the Olympic Peninsula. Council bylaws provide for an executive board and standing committees. Ad hoc committees may be created to address a specific issue. The eight-member executive board is composed of three officers and at least one member-at-large from each county.

In addition to the Executive Board, there are three standing committees: Injury Prevention & Public Education, Training, Education & Development (which includes the Conference Planning Sub-Committee), and the Planning & Standards Committee. The Regional Council also provides administrative support to the West Region Quality Improvement Forum (QIF), see page 37 and the Emergency Nursing Education Cooperative, see page 40.

Mission Statement: The mission of the West Region Emergency Medical Services and Trauma Care Council is to assist and guide local EMS and trauma care providers in the coordination and improvement of emergency medical services and injury prevention/public education in the West Region.

Vision Statement: We envision a tenable regional EMS and Trauma System with a plan that:

- Keeps patient care and interest the number one priority
- Recognizes the value of prevention and public education to decrease trauma-related morbidity and mortality
- Preserves local integrity and authority in coordination with inter/intra-regional agreements

We envision the Council as a non-partisan facilitator, coordinator, and resource for regional EMS issues.

RCW 70.168.015(7): "Emergency medical services and trauma care system plan" means a state-wide plan that identifies state-wide emergency medical services and trauma care objectives and priorities and identifies equipment, facility, personnel, training and other needs required to create and maintain a state-wide emergency medical services and trauma care system. The plan also includes a plan of implementation that identifies the state, regional and local activities that will create, operate, maintain and enhance the system. The plan is formulated by incorporating the regional emergency medical services and trauma care plans required under this chapter..."

Need Statement:

The West Region EMS Council has an active all-volunteer membership with regular attendance at its eight annual Executive Board and Council meetings. Membership classifications provide a balance of hospital and prehospital trauma care and emergency medical service providers, local elected officials, consumers, local government agencies, local EMS and Trauma Care Councils and military prehospital and hospital providers. Representatives are recommended by each local EMS council for appointment by the Department of Health.

Although the Council enjoys an active and dedicated membership, ongoing recruitment and timely orientation of new members is necessary to maintain the health of the organization. There are also ongoing needs to: 1) annually review the regional council by-laws, and 2) support an annual budget and planning retreat. In addition, there is the need to review and develop staff and Regional Council roles and responsibilities for production of the biennial EMS & trauma plan.

Goals/Objectives/Strategies:

Goal 1: Council membership recruitment and orientation is reviewed and updated by the West Region Council and staff.

Objective 1: Regional Council recruitment strategies will be reviewed and developed at each sub-committee meeting of the Council by December 31, 2006.

***Strategy 1*:** Regional Council staff to place recruitment strategies on the agenda for each sub-committee by December 31, 2006.

Objective 2: Regional Council orientation for new members is updated by staff and presented to Council for approval by December 31, 2006.

***Strategy 1*:** Regional Council staff to update new council member orientation procedures and materials before presenting to Council on December 31, 2006.

Goal 2: The West Region EMS Council goals, budget and by-laws are annually reviewed.

Objective 1: Regional Council goals, budget and by-laws will be reviewed at the annual budget and planning retreat.

***Strategy 1*:** Invite full Council participation to attend the budget and planning retreat to be held in April of each biennium**.**

Goal 3: Roles and responsibilities for production of the biennial EMS & trauma plan are reviewed and developed by the West Region EMS Council.

Objective 1: By June 31, 2006, a design will be developed and in place detailing Council and staff participation and responsibilities in producing the FY07-08 biennial trauma plan.

Strategy 1: Discussion began at the April 2005 annual budget and planning retreat. Roles and responsibilities to be developed at FY06 Council meetings.

Goal 4: System costs can be estimated.

Objective 1: Identify methods that will provide information on system costs by December 2006 and incorporate estimated system cost in the 2007-2009 biennial plan.

***Strategy 1*:** Regional Council staff to place discussion of system costs of goals on the agenda for each sub-committee by June 2006 or earlier.

Costs:

- System costs: Indeterminable
- Regional Council cost: $30,000 for overhead for attending or conducting meetings

Barriers: None at this time.

III. Injury Prevention & Public Information/Education

System Status - West Region:

Table A. West Region Injury Data

NON-FATAL INJURY HOSPITALIZATIONS 1998-2002			
Cause	**Count**	*Rate* per 100,00 resident population* ***West Region***	***WA State***
Falls	14,920	279.5	281.0
Motor Vehicle Crashes (Occupant)	2,717	50.9	46.4
Suicide / Self Inflicted	2,628	49.2	48.5
Poisoning	1,265	23.7	35.4
TOTAL	21,530		

FATAL INJURIES 1998-2002			
Cause	**Count**	*Rate* per 100,00 resident population* ***West Region***	***WA State***
Suicide	772	14.5	12.8
Motor Vehicle Crashes (Occupant)	537	10.1	9.2
Falls	395	7.4	7.0
Poisoning - Unintentional	367	6.9	6.9
TOTAL	2,071		

** Rate not calculated for values <5*
Data Source: Washington State Department of Health, Center for Health Statistics, Death Records & Comprehensive Hospital Abstract Reporting System

Injury Prevention and Public Education (IPPE) within the West Region is implemented and thriving because of the commitments and dedication of the many volunteers and professionals within prehospital and healthcare agencies, county and city governments, and local coalitions.

The regional prevention program is overseen by the volunteer membership of the West Region Injury Prevention and Public Education Committee and is staffed by a coordinator from the West Region office. The Committee provides a venue for the IPPE community to organize, collaborate and provide funding opportunities to relevant projects and programs. The committee includes representation from active injury prevention coalitions in each county, the designated trauma centers and local fire departments, as well as other individuals interested in prevention and public education. Participating coalitions include but are not limited to the following:

County and Agency of West Region Injury Prevention Partners
GRAYS HARBOR and N. PACIFIC
Grays Harbor Child Passenger Safety Coalition
Grays Harbor Community Hospital (Falls Prevention Outreach through the ED)
Grays Harbor Traffic Safety Task Force
Pacific County Traffic Safety & Injury Prevention Task Force
Seniors & Law Enforcement Together (SALT)
Westport Fire Department & South Beach EMS
LEWIS
Lewis County DUI/Traffic Safety Task Force
Lewis County Restraint Coalition
PIERCE
Good Samaritan Community Healthcare
Pierce County SAFE KIDS Coalition
Remembering When Coalition of Pierce County
Tacoma/Pierce County DUI Task Force Tacoma/Pierce County Health Department
Trauma Nurses Talk Tough (MultiCare Health Systems)
THURSTON
City of Olympia Safe & Sober Program
Thurston County Falls Reduction Through Education & Exercise (FREE)
Thurston County Fire District #11
Thurston County SAFE KIDS Coalition
Thurston County DUI Task Force

The committee reviews injury data for deaths and hospitalizations in the region and for each county. Mechanisms of injury are evaluated in relation to count, incidence, and age. This data is used in conjunction with committee discussion to make decisions on prevention project priorities that receive regional funding.

The committee ensures that funding is provided to reliable organizations that document their program effectiveness. Through meeting bimonthly, the committee strengthens communication, promotes cooperation and reduces duplication of effort among community members, EMS, hospitals, public health and other public safety agencies. The committee also provides opportunities to integrate discussion of local, regional and state perspectives and activities into the field of injury prevention and public education.

Additionally, committee members coordinate and produce an annual 4 hour prevention workshop at the West Region EMS Conference in Ocean Shores. The Region's prevention coordinator attends local prevention coalition meetings and is an active member of the state Injury Prevention and Public Education Technical Advisory Committee (IPPE TAC). There is one membership position for a prevention specialist on the West Region EMS Council and there are two membership positions on the West Region Quality Improvement Forum representing pediatric and adult injury prevention.

The Regional Council commits a portion of its annual budget to support regional injury prevention activities as prioritized by the West Region Injury Prevention Committee and approved by the Council.

The West Region Injury Prevention and Education Committee appropriated ¼ of its 2005 budget to support the growth of existing and new falls prevention programs and education in the West Region. Presently, the region supports FREE (Fall Reduction Through Education & Exercise), administered through Providence St. Peter Hospital, and an exercise/education program provided through Grays Harbor Community Hospital in Aberdeen. These programs most often target individuals who have fallen at least once in the past year or are at risk for falling. The education and prevention activities focus on exercise, home fall hazard evaluations and installing risk reduction devices when necessary. The committee is actively encouraging new fall prevention programs within the region.

The West Region Council has ongoing partnerships with several other local prevention committee and coalitions. Mini grant funding provides child passenger safety seats to the Pacific County Task Force and the Lewis County Restraint Coalition, life jackets to the Grays Harbor Safety Task Force and bicycle helmets to Grays Harbor Passenger Safety Team and Westport Fire Department. Helmet fitting videos are distributed to the Pierce County Safe Kids Coalition and education and training materials have been provided to the Pierce County DUI Impact Panel and the Olympia Safe & Sober Driving Program.

The region has also partnered with the Washington Poison Center (WPC) to receive prevention materials and information. A representative of the WPC will present at the 2006 West Region EMS Conference on what first responders can do to decrease the number of injuries and deaths by poisoning. Additionally, the region is working with the Crisis Clinic of Thurston County to create an outreach program for the Teen Care Line.

Need Statement:

West Region injury prevention needs are captured in the fatal and non-fatal injury data provided in Table A and illustrate the top three areas of concern are falls, motor vehicle crashes, and suicide.

Falls are the number one cause of nonfatal hospitalization injuries in the West Region, and are the third cause of death from injury in the West Region. 75% of hospitalizations for falls in the West Region occurred in individuals over 55 (*Source: Washington Dept. of Health Center for Health Statistics, 2002)*. This data reflects a need for seniors within the West Region to receive protection from and education regarding falls.

Motor vehicle crashes account for much of the unintentional childhood injury-related deaths in the West Region. Washington state injury data shows that 45% of the Washington children who died in a motor vehicle crash were unrestrained by a child safety seat or seatbelt at the time of their death (Washington State Childhood Injury Report, 1999-2001). Therefore, pediatric safety programs that promote child passenger safety continue to be a top priority.

Motor vehicle related injuries and deaths are still high on the list for the adult population. 39% of the traffic fatalities in the West Region are alcohol related (FARS Prepared by WTSC 2001). Hence, there is a regional need to continue to support impaired driving prevention programs.

With the high incidence of suicide within the region, the committee has identified the need to support programs which target the youth and adult high-risk population.

Adequate funding for the prevention program activities of West Region EMS and Trauma Care Council continues to be an issue, though the Council has been able to execute and support some strong programs with the funds currently available. The fiscal year 2005 budget allocated $25,000 of primary funds for use within this program. This allocated amount does not include the salary costs associated with having a .5 FTE program coordinator, nor does it include the costs associated with the annual Prevention workshop at the West Region EMS Conference. The Prevention workshop has seen increasingly higher attendance and received positive evaluations over the past three years. The content is specifically geared to EMS providers and coalition members. Several community-based prevention projects in the West Region have been started as a direct result of knowledge and skills gained at one of the annual workshops.

Goals/Objectives/Strategies:

The intent of the Regional Council, as expressed through its Prevention Committee and supported by the Washington State Department of Health, is to reduce death and disability due to injuries in the West Region. This wish is the main goal and mission of the Committee and is addressed through the implementation of several objectives as listed below.

Goal 1: Reduce death and disability due to injuries in the West Region through activities and awareness.

Objective 1: Reduce the rate of fall-related injuries and deaths among seniors by 2% within the West Region by providing fall protection and education programs. Falls will be reduced from 279.5 to 274 (hospitalization per 100,000 population) by June 30, 2006. *(2006 data will be reviewed when available from the state in 2008.)*

Strategy 1: Continue to support the growth of existing falls programs within the West Region through direct funding of programs.

Strategy 2: Continue to support the growth of new data-driven fall reduction and prevention programs within the West Region through direct funding of programs.

Objective 2: Sponsor at least one educational event in FY06 and FY07 that provides didactic and hands-on experience with prevention principles and practices for EMS and trauma care providers.

Strategy 1: Prevention Committee of the Council will plan an annual prevention workshop to be held at the West Region EMS Conference.

Strategy 2: Attempt to obtain state grants for additional support when the workshop

includes a DUI-related topic.

Objective 3: Update the Injury Prevention section of the West Region website quarterly to allow the regional office to better act as an informational resource for 1) injury prevention and public education specialists, 2) EMS and trauma care system providers, as well as 3) the general public.

Strategy 1: Maintain ongoing staff support, whether paid or volunteer, to keep the West Region website and office up to date and relevant with regional information on injury prevention and public education as well as activities within the EMS and trauma care system.

Objective 4: A prevention topic will be highlighted at least once during the FY06-07 biennium at the West Region Quality Improvement Forum (QIF).

Strategy 1: The Prevention Committee Chair and West Region staff will organize one educational presentation for the West Region QIF during the biennium.

Objective 5: Annually support data driven pediatric safety programs promoting best practices.

Strategy 1: Provide funding to county coalitions that aim to educate the public about and increase the use of child passenger safety seats. 100 child safety seats will be awarded to coalitions that target low income families at car seat inspection events.

Strategy 2: Support bicycle safety and the correct usage of bicycle helmets in all counties of the West Region through annual distribution of helmets. 500 helmets will be distributed. The Prevention Committee will determine a method to evaluate and measure if these efforts are increasing the percentage of children wearing helmets.

Strategy 3: Support teen suicide prevention programs in the West Region through funding of county coalitions that fall within the Prevention Committee's identified criteria.

Objective 6: Reduce the death and injuries rates from motor vehicle crashes by 2% by working with community programs and resources.

Strategy 1: Support DUI prevention programs in the West Region through funding of county coalitions that fall within the Prevention Committee's identified criteria. Evaluate effectiveness.

Criteria developed for grant evaluation by the West Region Grant Review Committee:

Question	Description	Max Points Possible
1	Problem being addressed ✓ What is the need? ✓ How many people are impacted by the problem	15
2	Supporting data presented	15
3	Project description ✓ How many people do you plan to reach	10
4	Objectives: ✓ Specific ✓ Measurable ✓ Attainable ✓ Realistic ✓ Time-based	10
5	Strategies: ✓ Specific tasks to reach objective(s)	10
6	Evaluation Plan ✓ How will you know if you reached objectives	15
7	Timeline	5
8	List of Partners ✓ Supporting agencies ✓ Letters of support	5
9	Complete Budget Presented	5
10	West Region Prevention Priority: Non-Fatal 1998 - 2002 ✓ Falls 279.5 per 100,000 ✓ MVCs 50.9 ✓ Suicide 49.2 ✓ Poison 23.7 ✓ Fire/burn 9.2 ✓ Pedestrian 7.2 ✓ Bike/vehicle 1.6 ✓ Drowning 0.9	10
Total		100 possible

Objective 7: Pursue at least one additional funding source during the biennium, such as corporate and foundation grants, and additional DOH grants that could supplement contractual funding received from the Department of Health, which is allocated by the West Region Council to prevention programs.

Strategy 1: Monitor relevant sources for possible funding opportunities, and apply as staff time allows.

Costs:

- System costs: $99,153.00
- Estimated Regional Council costs: $56,653.00

Barriers:

- Evaluation and measuring effectiveness of bicycle helmet sales and giveaways.
- Soliciting grant proposals that match West Region prevention goals and objectives.

IV. Prehospital

A. Communication

For current practices, refer to:

Council Operating Policy #1: System Access
Council Operating Policy #2: Communications
Council Operating Policy #3: Dispatch
Patient Care Procedure #1: Medical Command at the Scene
Patient Care Procedure #7: EMS/Medical Control-Communications

System Status - West Region:

Table B. Dispatchers with EMD Training by County

County Name	Total # of Dispatchers in the County	EMD Training Program/s used in the County (if none indicate so)	# Dispatchers within the county who have completed EMD training from a course in column #3
Grays Harbor *(excluding Quinault Indian Nation)*	19	Training program was developed in-house, reviewed & approved by the Grays Harbor Medical Program Director	19
Lewis *E9-1-1/Comm Center*	20	Modified King County CBD	19
Pierce: *FIRECOMM Puyallup City Comm Tacoma FD Buckley MADCOMM*	64 combined	King County CBD & APCO-EMD	47
North Pacific *PACCOM*	10	EMD	10
Thurston *CAPCOM*	51	CBD	51
Region Totals	164	Total not required	

All of the regional communications resources polled have effective 9-1-1/E-9-1-1 access, including wireless technology and have a centralized call-receiving center and central dispatch, with the exception of Pierce County. Trained emergency medical dispatchers routinely provide dispatch to EMS and bystander care. If necessary, all resources have the ability to track the time from initial 9-1-1 calls to the dispatch of the responding EMS agency.

All polled resources experience call volume overload to a greater or lesser degree. For example, because of the proliferation of cell phones, instead of receiving one call for a collision on the I-5 corridor, call centers will receive 20-40 calls all at the same time. Work being done to alleviate dispatch center call receiving overload is addressed for each county in the Needs Statement below.

With the exception of Pierce County, all regional communications resources share their dispatch center with other disciplines; therefore it is difficult to isolate the cost of state-of-the-art communication technology equipment specifically for EMS. However, the annual operations cost for Thurston County CAPCOM, including staff, equipment replacement,

radio coverage expansion/improvement, CAD and E9-1-1 telephone software/hardware replacement and maintenance was $5.4 million in 2004. Thurston County is currently in the process of working with a CAD vendor and Thurston County Medic One to add Safety Pad™ (a software and tablet PC solution for patient care data recording/reporting) for Medic One service providers which should be completed in 2006. That cost will approximate $90,000 for ALS hardware alone.

Regional EMS providers currently communicate with dispatch through radio, Nextel, mobile data computer or cell phone.

A comprehensive communications plan for Homeland Security Region 3 (Grays Harbor, Lewis, Mason, Thurston & Pacific Counties) is currently being researched through a CDC grant to Thurston County Public Health. Although this plan focuses mainly on public health and hospitals, it will include addressing the ability of EMS agencies to communicate with receiving hospitals.

Need Statement:

Communications systems continue to function on a regular basis in the region; however there is concern over how multiple patient, mass casualty, or other disaster incidents will strain systems in place. This issue has begun to be addressed through efforts between Homeland Security Region 3 and the Hospital Emergency Preparedness & Response Program of DOH.

Homeland Security Region 3 hospitals have requested HRSA grant funds to enhance the capability of the WHEERS (Washington Hospital & EMS Emergency Response System) communications system in the Region. This funding would provide additional radio repeaters within the region, as well as providing radios to hospitals and EMS agencies.

Although our region utilizes several types of communication systems, including cell phones and VHF communications (including HEAR), consistency, commonality, and interoperability between agencies needs to be addressed.

Some of our region's agencies respond in very remote locations so all systems are not available to all agencies. Cell phone communications are limited by location of towers and HEAR radio communications are distance- and topography-sensitive; both systems have significant capacity issues especially in a disaster/MCI. The WHEERS system mentioned above would alleviate some of these limitations during a Mass Casualty Incident.

Radio coverage improvement is needed in large buildings such as state buildings, hospitals, malls and schools in Thurston County. Funding is needed to help smaller fire districts replace older wideband radio technology with narrowband-compliant equipment. There is a lack of frequencies and overloaded channels cannot be divided until the transition to narrowband technology is complete.

Funding is needed to offset the expense of training, covering both the people getting the training and the staff covering that person during the training. Although training through drill scenarios is historically very effective, it can be cost prohibitive. Funding is needed to cover regional, multi-agency drills where communication issues can be actively addressed at the responder level.

Dispatch Center Overload

Grays Harbor & N Pacific Counties: The ability to communicate with outside agencies has been identified as a need; there is limited resolution due to remote location and cell phone limitations.

Lewis County: Lewis County has a High Incident Response Load (HIRL) plan in its procedures manual that was released in May 2005. Some agencies within the county have the capability to receive and respond when dispatch is overloaded. Others will need to develop the capability to receive non emergency calls and handle them outside the 9-1-1 system.

Pierce County: Dispatch centers polled have automatic transfers to other Public Safety Answering Points (PSAPs). When Madigan Army Medical Center dispatch is overloaded with calls, they overflow to Military Police or the Ft. Lewis Fire Department. Work related to this issue: A new communications center is under construction at Ft. Lewis promising new equipment and a centralized center with frequent training.

Thurston County: CAPCOM has a HIRL plan that is utilized when dispatch center overload occurs. It is determined by volume, and the fire dispatcher makes the determination. If the volume exceeds capability, the plan can be activated with a page to all fire departments alerting them to staff their Emergency Coordination Center (ECC) so that lesser priority calls can be transmitted directly to the appropriate ECC via CAD printer or fax. CAPCOM continues to handle priority 1 and 2 calls as normal and when the volume returns to a manageable level the HIRL is terminated and each department reports the status of their units. CAPCOM records the status reports and resumes normal operations.

Goals/Objectives/Strategies

Goal 1: An effective West Region communications system.

Objective 1: Regional dialogue will be encouraged among emergency management, communications centers, prehospital EMS, fire districts, public health and hospitals by placing communication issues on the agenda for at least two Region 3 Hospital and Prehospital Preparedness meetings as well as two regional Council meetings within the biennium.

Strategy 1: Build upon relationships established through the Emergency Preparedness and Response Program

Costs:

- System costs: No funds are currently available to assist in statewide communications planning, though some opportunities may arise from the bioterrorism preparedness planning efforts.
- Estimated Regional Council costs: $20,000 overhead cost of attending or conducting meetings.

Barriers to a communication system that works throughout the region with every agency continues to be our geographical features, which cannot be changed. West Region is made up of foothills, valleys and large areas of open water which stress the limits of most communications methods. Cost is also a barrier to the completion of a region wide system.

B. Medical Direction of Prehospital Providers

System Status:

For current practices, refer to:

Patient Care Procedure #1: Medical Command at the Scene
Patient Care Procedure #11: EMS/Medical Control-Communications

West Region Medical Program Directors

Grays Harbor & North Pacific Counties: Daniel Canfield, DO

Lewis County: Patrick O'Neill, MD

Pierce County: Clark Waffle, MD

Thurston County: Joseph Pellicer, MD

The four Medical Program Directors (MPDs) within the West Region are a leadership resource and essential link between prehospital and hospital care within each of their counties. The MPD functions as a liaison between each of the counties and the regional structure.

The four MPDs are active at their local county levels. Medical off-line direction is delegated to the individual county MPDs. They are responsible for overseeing the development and implementation of protocols and establishing countywide quality assessment programs to assure quality care is provided by all prehospital providers. MPDs recommend training content to meet local county needs and training requirements established by DOH. Recommendations to DOH for certification and re-certification reside under MPD authority. The individual providers are responsible to the county MPD for documenting and demonstrating accomplishment of training requirements and skills.

All prehospital orders originate from local hospital base stations whose operations are overseen by the local MPD. As stated in WAC 246-976-920 (3) (a): In accordance with department policies and procedures, the MPD may delegate in writing any duties, other than those described in the WAC subsection (2)(c), (j), and (k), to other physicians. Online physicians (physician advisors) in the base stations are delegated by the county MPDs to provide medical direction to prehospital care personnel in the field. This direction is consistent with approved protocols.

All four MPDs have positions on the West Region Council and are responsible for annually reviewing the Regional Patient Care Procedures. Participation at regional council meetings is sporadic for some of the MPDs due to the limited time available to devote to meetings. MPDs also participate at the quarterly West Region Quality Improvement Forum meetings.

The MPD informs the region of the specific medical needs of the county they represent. With those specific needs in mind, a region wide patient care procedure for medical care can be established which meets the needs of all citizens within the region.

The Medical Program Directors are instrumental in developing county operating procedures which are done in conjunction with the county councils when specific needs arise. The unique nature of each county within a region makes the medical input from the MPD invaluable in developing the PCP and COP.

Need Statement:
The regional EMS system needs to provide funding to support the activities required of the MPDs. Additionally, it needs to be able to provide a practical forum for their free and open communication. The MPDs time is of limited availability and, therefore an efficient mechanism of communication between the MPDs is essential. Utilizing methods such as email and teleconferencing may be appropriate. This communication, however, cannot be done solely for the purposes of having the communication. It must be goal-oriented so as to make the utilization of the Medical Program Director's time efficient and effective.

Goals/Objectives/Strategies:

Goal 1: County MPDs fully participate in the regional EMS & trauma care system.

Objective 1: Include active MPD participation in Council meetings, the West Region QI Forum, and the annual EMS Conference sponsored by the West Region by June 2007.

Strategy 1: Solicit assistance through county EMS councils and trauma service coordinators to directly invite MPDs to regional meetings.

Strategy 2: Include the ideas of the MPDs in regional meetings.

Objective 2: Set up mechanisms to allow focused and goal oriented communication between the Medical Program Directors by June 2006.

Strategy 1: Set up an online chat forum for the four West Region MPDs through the West Region website. Keep the MPDs informed of regional topics and meetings through this forum.

Costs:
- System costs: Unknown
- Estimated Regional Council costs: Regional staff and MPD time.

Barriers: MPDs have limited time to devote to meetings.

C. Prehospital EMS & Trauma Services

System Status:

Table C. Prehospital Providers by County and Level

	FY04-05 Plan				FY06-07 Plan			
County	**FR**	**EMT**	**EMT-I**	**PM**	**FR**	**EMT**	**EMT-I**	**PM**
Grays Harbor	83	191	38	53	79	184	49	58
Lewis	12	210	3	26	16	199	3	32
North Pacific	30	42	6	5	24	27	7	5
Pierce	43	1351	8	317	30	1477	9	362
Thurston	24	357	1	49	19	403	1	50
Regional Totals	**192**	**2151**	**56**	**450**	**168**	**2290**	**69**	**507**

Grays Harbor, Lewis, North Pacific, Pierce and Thurston Counties all have Advanced Life Support (ALS) and Basic Life Support (BLS) coverage. Each county has a mixture of paid, volunteer, public and private responders that makes each system unique. Recruitment and retention of first responders has seen a decrease in the past two years. In some of the rural districts first responders and EMTs are not being replenished. In most of the rural counties there is not enough money to pay for training of volunteers.

The West Region Council provides 23% of its annual contractual funds to prehospital training. The Council maintains contracts with each of the county EMS Councils and Centralia Community College to deliver training to providers.
The West Region Training, Education & Development (TED) Committee oversees EMS and trauma care instructional programs for prehospital and hospital personnel within the region. In addition, the TED oversees one sub-committee: the West Region Conference Planning Committee. The Conference Planning Committee holds bi-monthly meetings to produce the annual West Region EMS Conference which delivers quality education to providers.

Skill maintenance is provided through BLS, ILS and ALS OTEP. ALS and BLS skills workshops are also offered at the annual West Region EMS Conference. Due to liability issues, many hospitals are now requiring that providers sign contracts to practice intubation skills at their facilities.

Multiple entities assist EMS in the West Region. The Coast Guard, search and rescue (SAR) organizations, the National Park Service at Mt Rainier National Park and the Crystal Mt. Ski Patrol provide help by retrieving patients from the water or wilderness areas. Others provide training services to EMS, such as Bates Technical College (Tacoma), Tacoma Community College, Grays Harbor EMS, Centralia Community College and Thurston County Medic One in Olympia. The Washington State Patrol, Sheriff's Departments, Ft. Lewis Military Police and other law enforcement agencies provide on-scene support. In the case of a disaster or terrorist event, affiliated agencies will work together with licensed EMS agencies in the region through state and local Department of Emergency Management and Homeland Security Regional offices.

Medical airlift service is provided by Airlift Northwest. Airlift Northwest also plays an active role in providing training for trauma nurses and EMS providers within the West Region. The recent loss of Ft. Lewis' Military Assistance to Safety and Traffic (MAST) leaves a current gap for hazardous scene/weather airlift.

Other affiliated agencies include:

- Weyerhaeuser ERT
- Transalta Centralia Mining
- McChord AFB Fire Dept
- Ft. Lewis Fire & Emergency Services
- American Red Cross

Need Statement:

As stated in the Status section, recruitment and retention of first responders has seen a decrease in the past two years; retention could be helped if training was paid for by the state to maintain certification. Although the region provides contractual funds to local EMS councils, these funds do not adequately cover the training expenses in the rural communities. The region is in need of continued Ongoing Training and Evaluation Program (OTEP) and Continuing Medical Education (CME) for all EMS providers within the region. Additionally, there is the need to support initial BLS training in parts of the region and quality improvement for EMS instructors/evaluators for all levels of training (CME, OTEP and initial).

Overall, there is a deficit within the instructor pool in the West Region. The Training, Education & Development (TED) Committee has discussed creating a shared instructor pool.

Training/education aids and equipment were identified by the region's providers and include the following:

- *Interactive EMS Training CDs*
- *PowerPoint training system*
- *Laptops, projectors & screens*
- *Combination DVD/VCR*
- *Interosseous Leg & IV Arms Manikin*
- *Laerdal HeartSim 200 Rhythm Simulator*
- *Laerdal Airway Management Trainer*
- *EMS Casualty Moulage Kits*
- *CPR Manikins (Infant, Child, Adult)*
- *Difficult Airway Manikin*
- *Adult Airway Manikin*
- *Intubation Heads*
- *Laerdal Infant Intubation Trainer*
- *Laerdal AED Trainer*
- *Phillips Heartstart AED Trainer 2 with Remote*
- *Advanced Childbirth Simulator*
- *SimMan ALS Manikin*

Basic and state-of-the art emergency medical care equipment has been also identified as follows:

- *Scoop Stretcher*
- *Stairchair*
- *Low Angle Rescue Equipment*
- *Gurney*
- *Sager Traction Splints*
- *Fiberglass Backboards*
- *Pediatric Backboards*
- *Zoll ECG Monitor with ETC02 & 12 Lead*

Goals/Objectives/Strategies:

Goal 1: The needs of the OTEP and CME within the West Region are supported by the Regional Council.

Objective 1: Provide partial funding to support OTEP and CME annually.

Strategy 1: Contract annually with local county EMS council or designated representative to coordinate and conduct CME and OTEP at the local level.

Strategy 2: Provide training through annual West Region EMS Conference sponsored by the Council.

Objective 2: Partial funding and/or support to counties that express need for initial BLS training is annually supported by the region.

Strategy 1: The Training, Education & Development Committee (TED) reviews requests for funding and forwards to the Council for approval.

Objective 3: Counties annually submit needs for support and/or funding for initial BLS training within the biennium.

Strategy 1: The Training, Education & Development Committee (TED) reviews requests for funding and forwards to the Council for approval.

Goal 2: The West Region has a stable SEI and instructor pool.

Objective 1: Assist counties with development of initial and other BLS instructor/evaluator workshops, as requested during each year of the biennium.

Strategy 1: Assist counties with funding or administrative support for initial BLS instructor/evaluation training, as recommended by the TED Committee

Strategy 2: Offer EMS instructor development session at annual EMS conference in February 2006 and 2007.

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Costs:

- System costs: unknown
- Estimated Regional Council costs: $140,242.00

Barriers: The primary barrier is expected to be financial impact upon the region.

D. Verified Aid and Ambulance Services

System Status:

Table D. Approved Min/Max numbers of Verified Trauma Services by Level and Type by County

County	Verified Service Type	State Approved - *Minimum Number*	State Approved - *Maximum Number*	Current Status (# Verified for each Service Type)
GRAYS HARBOR	Aid – BLS	9	12	11
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	4	6	3
	Amb – ILS	3	6	1
	Amb - ALS	6	6	6
LEWIS	Aid – BLS	8	21	2
	Aid –ILS	0	2	0
	Aid – ALS	0	2	0
	Amb –BLS	11	21	9
	Amb – ILS	1	6	2
	Amb - ALS	1	6	5
NORTH PACIFIC	Aid – BLS	3	4	1
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	0	0	0
	Amb – ILS	0	0	0
	Amb - ALS	1	1	1
PIERCE	Aid - BLS Φ Ω	1	14	13
	Aid –ILS	0	0	0
	Aid – ALS Φ	0	10	0
	Amb-BLS Ω	1	11	9
	Amb – ILS	0	0	0
	Amb - ALS Ω	1	13	12
THURSTON	Aid – BLS	8	8	7
	Aid –ILS	0	1	0
	Aid – ALS	0	1	1
	Amb –BLS	7	9	7
	Amb – ILS	0	1	0
	Amb - ALS	1	4	3

Φ Any current BLS agency may submit a variance request to upgrade to Aid-ALS.

Ω Any current Fire Department which provides EMS (city, town, county) may upgrade to Amb-ALS within their own jurisdiction. Any new application from an ambulance service must serve Buckley, PCFD #12, Eatonville, PCFD #15, Roy, McKenna, PCFD #17, Carbonado, Greenwater, PCFD #26, Ashford, Elbe, and PCFD #23.

The Council supports local agencies in meeting the requirements of WAC to assure adequate availability of prehospital aid and ambulance services for each response area, based upon agency response time standards, geography, and topography and population density. Identification of need and distribution of verified aid and ambulance services is determined by local EMS county councils in Grays Harbor/N. Pacific, Pierce and Thurston Counties. Each council has an operations committee that is responsible for recommending the minimum/maximum number of services for subsequent review and recommendation by the county EMS council. In Lewis County, this process is handled through collaborative discussions among the Medical Program Director, fire chiefs and private prehospital providers. Each county's recommendations are received for review by the Regional Council and forwarded to DOH for approval.

Table E. Trauma Response Areas by County

Key:

Aid-BLS = A	Ambulance-BLS = D
Aid-ILS = B	Ambulance-ILS = E
Aid-ALS = C	Ambulance-ALS = F

County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in each Response Areas * use key
Grays Harbor	1	Encompasses the geographic boundaries of GHFD # 1, GHFD # 5 and City of McCleary FD. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	A-2 F-1
	2	Encompasses the geographic boundaries of GHFD # 2 and Montesano FD. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	
	3	Encompasses the geographic boundaries of Aberdeen FD, Cosmopolis FD, Hoquiam FD, GHFD # 6, GHFD # 10, GHFD # 15, GHFD #17. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	A-5 F-2
	4	Encompasses the geographic boundaries of South Beach Ambulance, Westport FD, GHFD # 3, GHFD # 11, GHFD # 14. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	A-3 F-1
	5	Encompasses the geographic boundaries of Ocean Shores FD, Taholah FD, GHFD # 7, GHFD # 8, GHFD # 16. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	A-2 D-1 F-2
	6	Encompasses the geographic boundaries of GHFD # 4. EMS agencies closest to the rural and wilderness areas of the zone were used to determine responses to these areas.	D-1

County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in each Response Areas * use key
Lewis	**1**	Within the current city limits of the *City of Centralia and urban growth area*	F-3
	2	Within the current boundaries of the *City of Chehalis and urban growth area*	A-1 F-1
	3	Area 3 is located in the NW corner of Lewis County bordering Thurston County to the North, Grays Harbor County and Pacific County to the West, and on the South by an imaginary line proceeding due West from the intersection of US Highway 12 and I-5 and on the east by Interstate 5.	F-3 D-2 A-1
	4	Area 4 is bordered on the east side of Interstate 5, bordering Thurston County to the North and US Highway 12 to the south; the eastern border is the community of Mossyrock.	F-2 D-3
	5	Area 5 is located West of Interstate 5 and South of an imaginary line running west from US Highway 12 and Interstate 5 to Pacific Co, then South to Cowlitz County	F-1 A-1 D-2
	6	Area 6 is located East of Interstate 5 and North of the Cowlitz Co line bordering US Highway 12 to the North and Mossyrock to the East	F-1 D-4
	7	Area 7 is East from Mossyrock to Kiona Creek 5 miles west of Randle on Us Highway 12, then North to the Pierce Co line and South to the Cowlitz Co and Skamania Co line	D-4
	8	Area 8 is East on US Highway 12 from Kiona Creek to the Summit of White Pass at milepost 151 at the Yakima Co line, south to the Skamania Co and Yakima Co lines and North to the Pierce Co line/Nisqually River including the Mt Rainier wilderness area.	D-1 B-2
North Pacific	**1**	City of Raymond, City of South Bend, Pacific County FD # 3, # 6, # 7 & # 8 and all adjoining forest lands, both public and private. Encompasses FD # 5 to milepost 17 on Highway 105 and any adjoining forestlands, both public and private. Encompasses area of Pacific County in and around the community of Brooklyn in the northeast corner of Pacific County.	D-2 F-4
	2	Pacific County FD # 4 including the community of Naselle and outlying areas to include adjoining forest lands, both public and private.	D-1 B-2 E-2

County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in each Response Areas * use key
Pierce	**1**	**Area #1 (North)** Area 1 is bordered by Kitsap County in NE by an imaginary line running along 160th St east to Colvos Passage at water, then west along 160th St KPN to NW corner at Kitsap/Mason/Pierce counties border where the imaginary line goes south along 198th Ave KPN to water at Rocky Bay in Case Inlet to Thurston county border at Nisqually River at Nisqually Beach, then follows water line north to Chambers Creek Rd W, then east to Waller Rd, then north to River Rd, then east to Freeman Rd E, then north to Yuma St , then east to Meridian-Hwy 161 then north to an imaginary line bordering King County running west along 384th St through city of Milton to Pacific Hwy ,then north to a point at 7th St Ct NE where it runs NNW to a point at Water St in Dash Point. There it enters the water and crosses the Puget Sound to meet the point at Colvos Passage.	A-4 D-4 F-9
	2	**Area #2 (South)** Area 2 is bordered by Thurston County in SW at the Nisqually River at Nisqually Beach, then follows water line north to Chambers Creek Rd W, then along an imaginary line east to Waller Rd, then south along an imaginary line along Mountain Hwy to 260th, then west to 8th Ave E, then south along an imaginary line to Thurston county border at Nisqually River, then west along Nisqually River to Nisqually Beach.	A-1 D-2 F-8
	3	**Area #3 (East)** Area #3 is bordered by Thurston County in SW at a point where an imaginary line running south along 8th Ave E would then intersect the Nisqually River, it then follows the Nisqually River east to a Thurston, Pierce, and Lewis Counties junction at Hwy 7 in Elbe, then continues east along Nisqually River to Mt. Rainier Nat'l Park at end off Hwy 706 along imaginary line east to Yakima County border, then NE along imaginary line bordering Yakima, Kittitas, King, Pierce Counties junction at Green River, then west along Green Water River to junction with White River continuing NW along White River to a point in Muckleshoot Indian Reservation where the imaginary line goes along imaginary line along 1st Ave E west through Auburn, then along County Line west to 384th St west to Meridian-Hwy 161, then south to Yuma St, then west to Freeman, then south River Rd, then west to Waller Rd, then south along an imaginary line along Mountain Hwy to 260th, then west to 8th Ave E, then south along an imaginary line to Thurston county border at Nisqually River.	A-8 D-4 F-7
Thurston	**1**	City of Olympia jurisdictional boundaries	D-2 F-3
	2	City of Tumwater jurisdictional boundaries and FD# 15	D-2 F-3

County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in each Response Areas * use key
Thurston	**3**	City of Lacey jurisdictional boundaries and FD# 3 jurisdictional boundaries	D-2 F-3
	4	City of Yelm jurisdictional boundaries and FD# 2 jurisdictional boundaries	A-1 D-2 F-3
	5	City of Rainier jurisdictional boundaries and FD# 4 jurisdictional boundaries	A-1 D-2 F-3
	6	FD# 17 jurisdictional boundaries	D-3 F-3
	7	City of Tenino jurisdictional boundaries and FD# 12 jurisdictional boundaries	A-1 D-2 F-3
	8	Town of Bucoda jurisdictional boundaries	A-1 C-1 D-2 F-3
	9	FD# 16 jurisdictional boundaries	A-1 C-1 D-2 F-3
	10	FD# 1 jurisdictional boundaries	C-1 D-2 F-3
	11	FD# 5 jurisdictional boundaries	D-3 F-3
	12	FD# 6 jurisdictional boundaries	A-1 D-2 F-3
	13	FD# 7 jurisdictional boundaries	D-3 F-3
	14	FD# 8 jurisdictional boundaries	A-1 D-2 F-3
	15	FD# 9 jurisdictional boundaries	D-3 F-3
	16	FD# 11 jurisdictional boundaries	C-1 D-3 F-3
	17	FD# 13 jurisdictional boundaries	A-1 D-2 F-3

Trauma Response Area Maps by County are in Exhibit 1.

Need Statement:
Funding resources at the local as well as regional level continue to be an issue. Agencies attempting to comply with present state mandates in order to maintain verified status are often without the funds to do so. The regional council has occasional, but not steady opportunities to seek funding to pass through to individual agencies or departments, depending on the need.

Goals/Objectives/Strategies:

Goal 1: Special funding sources are available to assist West Region agencies or departments in need.

Objective 1: Annually monitor and apply for at least one grant opportunity presented through the State Department of Health and Federal agencies during the biennium.

Strategy 1: Get included on federal and state emailing lists that update agencies on state and federal funding opportunities and pursue those that are feasible and appropriate.

Objective 2: At least annually inform agencies within the region of any funding and/or grant opportunities.

Strategy 1: Forward all relevant grant information received to appropriate agencies within the region.

Costs:
- System costs: unknown
- Estimated Regional Council costs: unknown

Barriers: The main barrier expected is not having the time to pursue a particular opportunity when it comes along, due to other more pressing tasks and responsibilities.

E. Patient Care Procedures, County Operating Procedures & multi-county/inter-regional operations

System Status:
Prehospital patient care procedures (PCPs) are defined in writing and standardized for the entire region (see Exhibit 2). Annual review of these regional PCPs is the responsibility of the Medical Program Directors (MPDs) and subsequently the Department of Health (DOH). These patient care procedures are on file in each county. Individual provider agencies in the region receive updates of the PCPs.

County operating procedures must at least meet the minimum regional standard, and if they exceed the standard they must be reviewed by the Council and approved by DOH before implementation. To date, all West Region counties adhere to the regional PCPs. In addition, Pierce County has a state-approved County Operating Procedure (COP) that describes use of the state trauma triage tool in the county.

The MPD-approved patient care protocols are on file in each county. These protocols are reviewed regularly by the MPD and county EMS Council to verify they meet each community's medical needs and the state medical standards.

Need Statement

No changes have been recommended to currently adopted PCPs. West Region EMS Council continues to educate providers about the definition and role of regional patient care procedures, county operating procedures and council operating policies. The West Region has a need to provide an ongoing forum for discussion and refinement of regional patient care procedures and county operating procedures to support the provision of optimal care to the trauma patient through effective functioning of the EMS and trauma care system.

Goals/Objectives/Strategies:

Goal #1: The Regional Patient Care Procedures support optimal care of the trauma patient.

Objective 1: Regional Patient Care Procedures are reviewed on an annual basis, or more often if needed.

Strategy 1: Review PCPs at regional budget and planning retreat in April 2006 and April 2007.

Objective 2: County Operating Procedures, developed by local counties, are reviewed as needed.

Costs:

- System costs: Unknown
- Estimated Regional Council costs: Minimal

Barriers: No barriers are perceived for pursing a dialogue within the region.

V. Designated Trauma Care Services

A. Trauma Services

System Status:

Table F. Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma Care Services (General Acute Trauma Services)

Level	State Approved		Current Status
	Min	Max	
II	2	3	2 (1 joint)
III	1	6	3
IV	2	8	5
V	1	1	1
II P	1	1	1
III P	0	0	0

Table G. Approved Minimum/Maximum (Min/Max) numbers of Designated Rehabilitation Trauma Care Services

Level	State Approved		Current Status
	Min	Max	
II	3	4	2
III*	1	5	0

** There are no restrictions on the number of Level III Rehab Services*

Distribution of Trauma Services by County

TRAUMA CENTER LOCATION	TRAUMA CENTER LEVEL RECOMMENDATIONS
Regional (Pierce County)	1 Level II - Pediatric
Pierce County: due to geographical diversity & district population centers in Pierce County, WREMS recommends the distribution of Level II and III trauma centers throughout the county to include the west side, east side and south side of the county.	1 Adult Level II – Civilian 1 Adult Level II – Military 2 Adult Level III or IV
Thurston County	1 Level II or III **AND** 1 Level IV
Lewis	2 Level III or IV
Grays Harbor County	1 Level III or IV 1 Level IV or V
Northern Pacific County	1 Level IV

Trauma Service Designation – West Region Hospitals

Adult	Pediatric	Rehab		
II			Madigan Army Medical Center	Fort Lewis
II			Tacoma Joint: St. Joseph Medical Center Tacoma General Hospital	Tacoma
III		IR&I-PR	Good Samaritan Community Healthcare	Puyallup
III			Grays Harbor Community Hospital	Aberdeen
III			Providence Centralia Hospital	Centralia
III		II-R	Providence St. Peter Hospital	Olympia
IV			Capital Medical Center	Olympia
IV			Morton General Hospital	Morton
IV			St. Clare Hospital	Lakewood
IV			Willapa Harbor Hospital	South Bend
V			Mark Reed Hospital	McCleary
	II-P		Mary Bridge Children's Hospital	Tacoma
		II-R	St. Joseph Medical Center	Tacoma

P=Pediatric Trauma Svc R=Trauma Rehab Svc PR=Pediatric Trauma Rehab Svc

The West Region is fortunate in the number and distribution of hospitals and healthcare facilities that are appropriate for the successful implementation of a region wide trauma system. There are 13 designated trauma care services currently operating within the region. Madigan Army Medical Center (MAMC), located inside Fort Lewis, is an adult Level II center. Although MAMC's primary recipient of care is military beneficiaries, the hospital will care for civilian trauma patients as needed or when the Tacoma Level II is on divert status.

Diversion of the trauma patient within the West Region varies according to county and facility. Pierce County has adopted a County Operating Procedure (see Exhibit 2) utilizing a Prehospital Trauma Triage Destination tool which is an algorithm. The algorithm lists criteria which clearly define the Step 1, 2 and 3 trauma patients along with the destination for definitive care for these patients.

Pierce County EMS providers follow the guidelines of the algorithm to determine the destination for their trauma patient. If the destination facility is on "divert" for trauma patients, EMS is to go to the next closest trauma facility of equal or higher destination. Providers may also decide to transport by ground or air to Harborview Medical Center. They must take into consideration the condition of the patient related to stability of the airway. A trauma patient with an unstable airway is taken to the nearest facility.

Pierce County "divert" for trauma patients is not to be confused with the "no-divert" policy for Pierce County medical patients. The Pierce County EMS Divert Plan (PCDP) went into effect January 1, 2005. It allows for limited medical divert in the afternoon to evening hours, giving a safety valve to the emergency rooms. This will gradually be diminished until January 1, 2006 when all Pierce County receiving centers will eliminate the practice of diverting adult medical patients. For questions related to the PCDP please contact Clark Waffle, MD, MPD, Pierce County EMS.

Tacoma Trauma Services, a joint adult Level II, was established by Tacoma General Hospital and St. Joseph Medical Center in June 2000. Mary Bridge Children's Hospital is the highest level of pediatric trauma designation (Level II) and Good Samaritan Community Healthcare is the highest adult and pediatric trauma rehabilitation service (Level I).

There are also four Level III trauma centers, four Level IVs, and one Level V. Trauma rehabilitation services include one Level I adult and pediatric trauma rehabilitation center (Good Samaritan Community Healthcare) and two Level II adult trauma rehab centers (providence St. Peter Hospital and St. Joseph Medical Center).

Designated trauma center representatives provide leadership for the West Region Quality Improvement Forum (QIF) per WAC 246-976-910. The majority of healthcare services in the West Region participate in the QIF. Monitoring trauma centers falls within the purview of DOH.

Need Statement:

The West Region Council provides recommendations for minimum and maximum numbers, levels and locations of adult, pediatric, and rehabilitation trauma designations to DOH. As of the writing of this report, the region has received no recommendations for changes.

Gaps in the current system related to hospital based trauma care include the ongoing shortage of trauma nurses. The West Region provides administrative support to the West Region Emergency Nursing Education Cooperative (ER Coop) which was established in 1997. The cooperative is a group of hospitals in the West Region that developed a program to train nurses interested in entering clinical practice in the emergency room. Cooperative members present 80 hours of didactic instruction, and students also receive certifications in PALS-equivalent, ENPC and TNCC.

In addition to the ER Coop, the West Region offers TNCC, ENPC, CATN, and ICU/CCU Trauma Education to nurses. Although these course offerings have been embraced by the trauma centers, the cost to the region has become prohibitive. Therefore, the regional council has begun decreasing the number of classes offered. The Council is dedicated to assisting all of the regional trauma centers with the task of providing the necessary trauma education to their staff and helping establish hospital-based trauma education.

Goals/Objectives/Strategies:

Goal # 1: The number of trained emergency department, ICU and critical care nurses meets designated trauma care service needs in the West Region.

Objective 1: Provide annual administrative support to the West Region Emergency Nursing Education Cooperative as needed.

Objective 2: Assist the regional trauma centers by providing four WAC-required trauma education courses within the biennium. Support the efforts of the regional trauma centers to independently provide WAC-required trauma education to their staff.

Strategy 1: Facilitate planning meetings for the regional trauma centers to organize trauma education within the region for FY06 and FY07.

Costs:

- System costs: unknown
- Estimated Regional Council costs: $46,776.00

VI. EMS And Trauma System Evaluation

A. Information Management

System Status:

The West Region Council has been involved in statewide planning for the Washington EMS Information System (WEMSIS) through participating in conducting surveys which query EMS providers on the type of electronic software they use to collect data. Representatives of the Council attend the DOH EMS Registry TAC and regularly deliver reports to the Council on the planning process.

The West Region Council supports the participation of prehospital and hospital providers in the collection and transmission of data to the State Trauma Registry. Data transmission methods vary between individual agencies within each county; data is submitted to receiving facilities by transport agencies throughout the region. The hospitals then include that data with their own trauma data submission to DOH.

The majority of transportation providers leave a written report with the patient at the hospital. In some cases, an electronic copy of the report is sent from the agency to the hospital after the call is complete. When additional documentation is needed by the receiving facility, EMS agencies are contacted promptly.

Several agencies within Pierce County utilize an electronic data collection program, yet do not all use the same program. Thurston County has developed a program for electronic transmission of data from the field to the hospital through the purchase of mobile data terminals. The program also allows for electronic dispatch data to be added to the patient record which is accessible by the EMS base hospital. ALS providers within Thurston County will be trained in the use of the devices in FY06.

Run time data elements are consistently filled out on many of the prehospital agency's run sheets. Some agencies do not have a place for documentation of these times on their run sheets. Contacting and obtaining this information from various dispatch centers can be difficult and time consuming. Information from some dispatch centers is forthcoming but slow.

Submission of timely prehospital trauma data to receiving trauma services is mixed. Some prehospital agencies submit timely data while others send their run sheets to another region or state for storage causing a delay in delivery of the data to the hospital.

The West Region Quality Improvement Forum (QIF) regularly addresses the issue of prehospital submission of data to the region's trauma centers at its quarterly meetings. Trauma Coordinators have reported an improvement in EMS documentation skills over the last year.

Need Statement:

The Council is committed to assisting the DOH in developing a statewide data collection system which will help all EMS agencies by developing a means to collect, link and analyze information.

The QIF will continue to address the timeliness and completeness of prehospital data submission to the region's trauma centers at its confidential quarterly meetings. Prehospital participation at the QIF is an integral part of case presentations which scrutinize the continuum of care. When appropriate, the QIF will make recommendations to the Council regarding how to best assist prehospital or hospital agencies encountering difficulties with data collection and submission.

Goals/Objectives/Strategies:

Goal 1: The West Region uses electronic data collection and information systems that link prehospital, hospital and dispatch.

Objective 1: Representatives of the Council attend the scheduled DOH EMS Registry TAC meetings throughout the year and regularly deliver reports to the Council on the planning process.

Objective 2: The West Region Council completes necessary contract deliverables toward establishing a statewide data collection system within the biennium.

Costs:

- System costs: unknown
- Estimated Regional Council costs: $2,500.00

B. Quality Assurance

System Status:

The West Region Quality Improvement Forum (QIF) evaluates the EMS and trauma system within the West Region, under the leadership of the designated facilities. This effort is in compliance with their responsibility for regional quality assurance as defined in WAC 246-976-910. The regional quality assurance plan was approved by DOH in May 1997, revised in March 2001, and revised again in November 2002. The revised Quality Improvement Plan is included here as Exhibit 4.

Responsibility for the internal quality assurance/quality improvement presentations, individual case presentations, and education is shared among the designated trauma facilities and prehospital agencies at the QIF. The overall agenda is inclusive of the full continuum of care. There are three vital components at each meeting: 1) review of regional data and trends, 2) performance improvement project presentations, and 3) focused case reviews with directed discussion. The State Trauma Registry data presented enhances the efforts to improve trauma patient care and is utilized if system changes are needed. West Region representation to the forum includes the Council Chair, committee chairs, MPDs, and many other representatives of the Regional Council. The region also provides administrative and meeting support to the quarterly QIF meetings.

When an opportunity for improvement or educational need for a prehospital agency is identified at a Pierce County facility, the data is collected and contact is made with an MSO at the agency involved. If available, the audio clip from the run report is accessed to further clarify or identify additional problems. These QI/QA opportunities may be addressed in several ways. EMS and medical facility staff involved with the run are given an opportunity to explain the situation from their perspective, and then receive the educational elements identified as lacking. Following this process, the education of other EMS providers will take place either during the agency's base station meeting, by printing off and circulating informational flyers, or by compiling and presenting the case for the whole agency or county through the QI/QA process. (base station meetings, county EMS QA meetings, regional EMS QA/QI meetings or regional EMS workshops)

MPDs work with their local councils to provide oversight of QI for prehospital agencies. The Grays Harbor and Lewis County MPDs participate regularly at the West Region Quality Improvement Forum.

Need Statement:

There is the need to continue to sustain the strong interest and support new growth of the West Region Quality Improvement Forum. There is also the need to provide quality improvement/assurance training to prehospital and hospital personnel.

Goals/Objectives/Strategies:

<u>Goal #1: EMS and trauma system evaluation is overseen at the regional level by the West Region Quality Improvement Forum.</u>

<u>Objective 1:</u> Administratively support the vital quarterly activities of the West Region Quality Improvement Forum.

Strategy 1: Provide administrative support to all QIF meetings scheduled in FY06-07.

<u>Goal #2: Prehospital and hospital quality assurance/improvement training and education is supported by the Regional Council.</u>

<u>Objective 1:</u> Provide QA/QI training and education sessions at the annual West Region EMS Conference in February 2006 and 2007.

Costs:

- <u>System costs:</u> unknown
- <u>Estimated Regional Council costs:</u> $6,000.00

VII. All Hazards Preparedness

A. Prehospital Preparedness

System Status:
The West Region Council has contracted with the Department of Health, Hospital Emergency Preparedness & Response Program to facilitate and coordinate prehospital and hospital all hazards planning within Homeland Security Region 3. Region 3 is defined as including Grays Harbor, Lewis, Mason, Pacific and Thurston Counties and excludes Pierce County (which is Region 5).

The Council collaborates with Thurston County Public Health to accomplish deliverables as outlined in CDC and HRSA grants for Region 3. In addition to working with the hospitals and prehospital agencies, the Council also collaborates with Homeland Security Region 3, local emergency management and public health jurisdictions and Native American tribes within the region.

The Regional Council has facilitated all hazards meetings with representation from prehospital agencies and hospital personnel. Prehospital and hospital have met to discuss Regional Disaster Medical Hospital Control, the Region 3 Hospital Preparedness Plan, mutual aid agreements, and trauma and burn care capability and needs. Disaster and emergency response exercises have been conducted at the county and regional level. Two Homeland Security regional exercises have been conducted to date, a biological weapons tabletop exercise in June 2004 and a functional exercise in February 2005.

PPE and decontamination equipment has been received by some prehospital providers through the Office of Domestic Preparedness grant managed at the county level. The Council does not currently keep a prehospital WMD equipment log.

The Public Health Regional Learning Specialist, Emergency Management, the DOH Office of EMS and Trauma Systems, and the Regional Council are working together to include EMS agency and hospital participation in state wide and regional emergency preparedness and response training. The Office of Domestic Preparedness is offering training to different disciplines to increase awareness and response capabilities to WMD incidents.

Mutual aid agreements between agencies are in place in all of the counties, some are being updated to include response to disasters.

As mentioned above, the Council does not currently have complete information available on equipment resources for prehospital interoperability. During mass casualty or multiple patient incidents, EMS agencies are instructed to contact the Regional Medical Control (RMC) Hospital, Providence St. Peter Hospital, for on-line medical direction and patient destination. There are no current WMD patient care procedures, protocols or guidelines other than to contact the RMC. Prehospital agencies will follow their county protocols, MCI Plan, and the West Region's PCPs. However, with DOH guidance, the region is tasked to develop a Regional PCP for providing trauma and burn care to at least 50 severely injured adult and pediatric patients of a mass casualty incident due to terrorism.

Need Statement:
As stated in the Prehospital Communications section, a comprehensive communications plan for Homeland Security Region 3 is currently being researched by Thurston County Public Health. Although this plan focuses mainly on public health and hospitals, it will include addressing the ability of EMS agencies to communicate with receiving hospitals.

Homeland Security Region 3 hospitals have requested HRSA grant funds to enhance the capability of the WHEERS (Washington Hospital & EMS Emergency Response System) communications system in the Region. This funding would provide additional radio repeaters within the region, as well as providing radios to hospitals and all ALS transport vehicles in Region 3.

Awareness training needs to be integrated into current training programs for prehospital. To do this, the Council will continue to collaborate with Homeland Security Region 3, Thurston County Public Health, and the nine regional hospitals in preparedness exercises and training for WMD incidents.

The Council does not currently have complete information on the existing needs for WMD equipment or for an all hazards mutual response agreement. As stated above, the Regional Council has been tasked with developing a PCP for field care, equipment and transport for 50 burn patients per million population per day.

Goals/Objectives/Strategies:

Goal #1: Prehospital all hazard preparedness needs are identified.

***Objective 1*:** The Council will coordinate activities and complete projects to accomplish the deliverables as identified in the annual contract between the West Region Council and the DOH Hospital Emergency Preparedness & Response Program.

Strategy 1: Oversee the distribution of WHEERS radio equipment to prehospital agencies with ALS transport units by November 1, 2006

Strategy 2: Identify the WMD training needs of prehospital providers by June 2006.

Strategy 3: Complete an inventory of the WMD equipment received by providers region wide by June 2006.

Strategy 4: Adopt a Patient Care Procedure for trauma and burn care at the regional level by June 2006.

Costs:

- System costs: unknown
- Estimated Regional Council costs: $10,000.00

B. Hospital Preparedness

System Status:

The West Region Council has contracted with the Department of Health, Hospital Emergency Preparedness & Response Program to facilitate and coordinate prehospital and hospital all hazards planning within Homeland Security Region 3. Region 3 is defined as including Grays Harbor, Lewis, Mason, Pacific and Thurston Counties and excludes Pierce County (which is Region 5). There are nine hospitals in Region 3 which are listed below:

REGION 3 HOSPITAL	LOCATION
Capital Medical Center	Olympia
Grays Harbor Community Hospital	Aberdeen
Mark Reed Hospital	McCleary
Mason General Hospital	Shelton
Morton General Hospital	Morton
Ocean Beach Hospital	Ilwaco
Providence Centralia Hospital	Centralia
Providence St. Peter Hospital	Olympia
Willapa Harbor Hospital	South Bend

The Council collaborates with Thurston County Public Health to accomplish deliverables as outlined in CDC and HRSA grants for Region 3. In addition to working with the hospitals and prehospital agencies, the Council also collaborates with Homeland Security Region 3, local emergency management and public health jurisdictions and Native American tribes within the region.

The Regional Council has facilitated all hazards meetings with representation from all of the disciplines listed above to discuss hospital equipment needs, Regional Disaster Medical Hospital Control, the Region 3 Hospital Preparedness Plan, mutual aid agreements, regional exercises and training, and trauma and burn care capability and needs. Disaster and emergency response exercises have been conducted at the county and regional level. Two Homeland Security regional exercises have been conducted to date, a biological weapons tabletop exercise in June 2004 and a functional exercise in February 2005. All nine hospitals participated in both exercises.

The first Region 3 Hospital Preparedness Plan was submitted to DOH in May 2003. The first update of the Plan was submitted to DOH in March 2004 and the second update of the Plan will be delivered to DOH in August 2005. The Council has been instrumental in coordinating the updates of the Plan with all of the necessary participants. The Plan has been updated using plan review comments, meeting outcomes, drill/exercise after action reports and advice from public health and emergency preparedness partners.

The Council works collaboratively with the Region 3 Public Health Regional Learning Specialist, to include hospital participation in state wide and regional emergency preparedness and response training. The Office of Domestic Preparedness (ODP) is offering training to different disciplines to increase awareness and response capabilities to WMD incidents. Region 3 has trained five individuals to conduct WMD awareness training to first responders; plans are in place to conduct two ODP WMD awareness trainings by August 2006.

Hospitals started receiving decontamination and PPE equipment through DOH and Homeland Security starting in September 2002. All facilities in Region 3 will have received equipment by August 2005.

Need Statement:

The Council will accomplish the required deliverables as outlined in its contract with the Department of Health, Hospital Emergency Preparedness & Response Program. Those deliverables include the following projects:

Regional Hospital Emergency Preparedness and Response Plan

The Council will work with the hospitals and other partners to keep the Regional Hospital Emergency Preparedness and Response Plan up to date as appropriate. Plan updates include specific requirements as outlined in HRSA benchmarks.

Awareness Training of Hospital Personnel

The Council will work collaboratively with the public health regional learning specialist and other partners to meet the goal of providing WMD awareness training to hospital personnel within Region 3.

Equipment

The Council will coordinate with the hospitals to identify and prioritize regional equipment needs which will enhance their capacity to respond to a public health emergency and enable them to meet the requirements of the regional hospital preparedness and response plan.

Drills/Exercises

The Council will work collaboratively with the public health regional learning specialist, emergency management agencies, the DOH Office of EMS & Trauma Systems to incorporate hospital participation in statewide and regional emergency preparedness and response exercises and training.

Enhanced Burn Care

With DOH's guidance, the Council will work with the hospitals to complete a survey that will identify hospital capability and needs to meet the goal of providing trauma and burn care to at least 50 injured adult and pediatric patients per million population per day.

Goals/Objectives/Strategies:

Goal #1: Hospital all hazard preparedness needs are addressed.

***Objective 1*:** Update the Regional Hospital Preparedness Plan by August 31, 2005 and August 31, 2006.

Objective 2: Oversee the distribution of WHEERS radio equipment to hospitals by November 1, 2006.

Objective 3: Complete any additional deliverables as requested to assist DOH in response to state, public health regional and local needs as they pertain to hospital emergency preparedness and response activities.

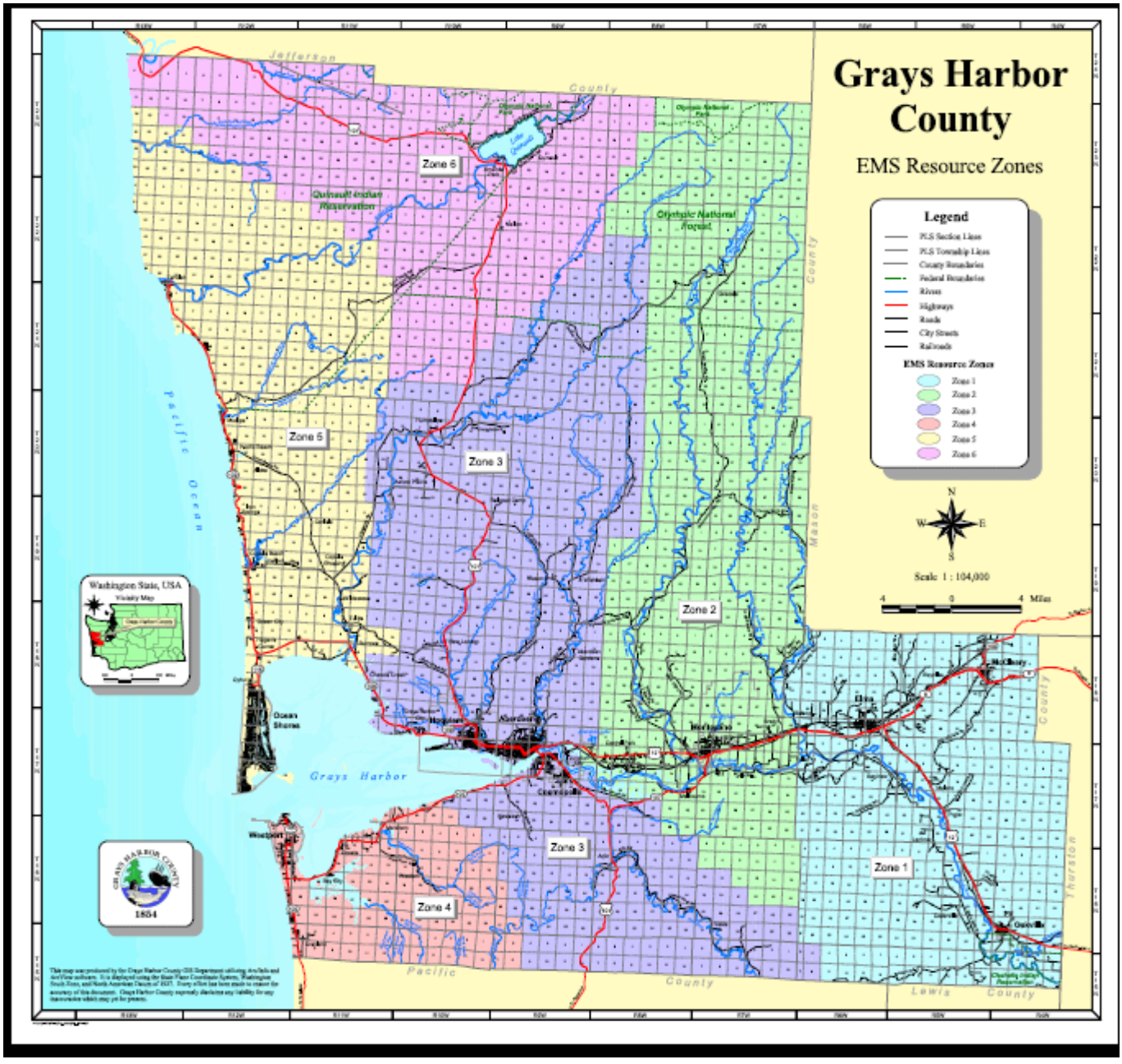
Costs:

- System costs: unknown
- Estimated Regional Council costs: $26,753.00

Exhibits

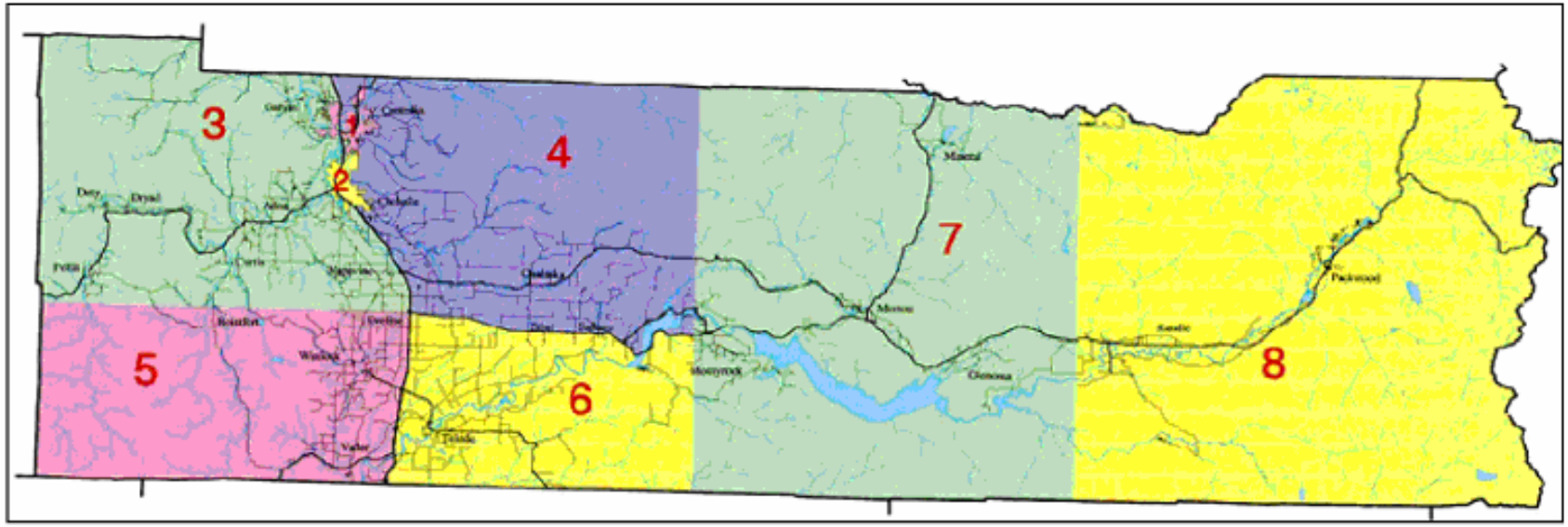
Exhibit 1 - County Response Area Maps

Grays Harbor County Response Area Map



Lewis County Response Area Map

Lewis County Emergency Notification Zones



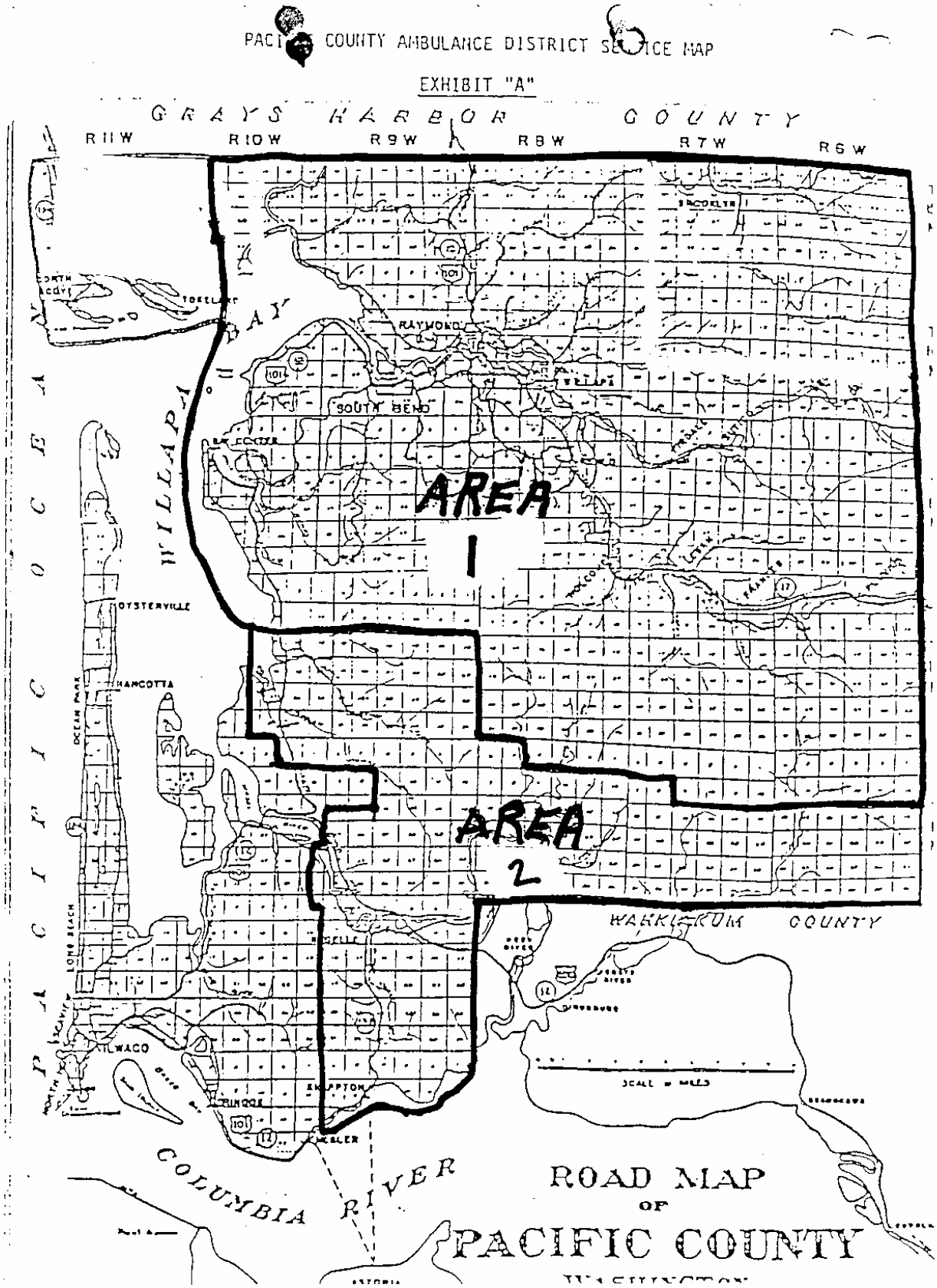
Lewis County Map Disclaimer:
These maps were developed and produced by Lewis County GIS. They are provided for reference only and are not intended to show map scale accuracy or all inclusive map features.

The base map was developed by the WA State Dept. of Natural Resources by scanning and digitizing USGS 1:24,000 quadrangle maps. As indicated, the accuracy of the map has not been verified and it should be used for informational purposes only. Any possible discrepancies should be brought to the attention of Lewis County GIS.

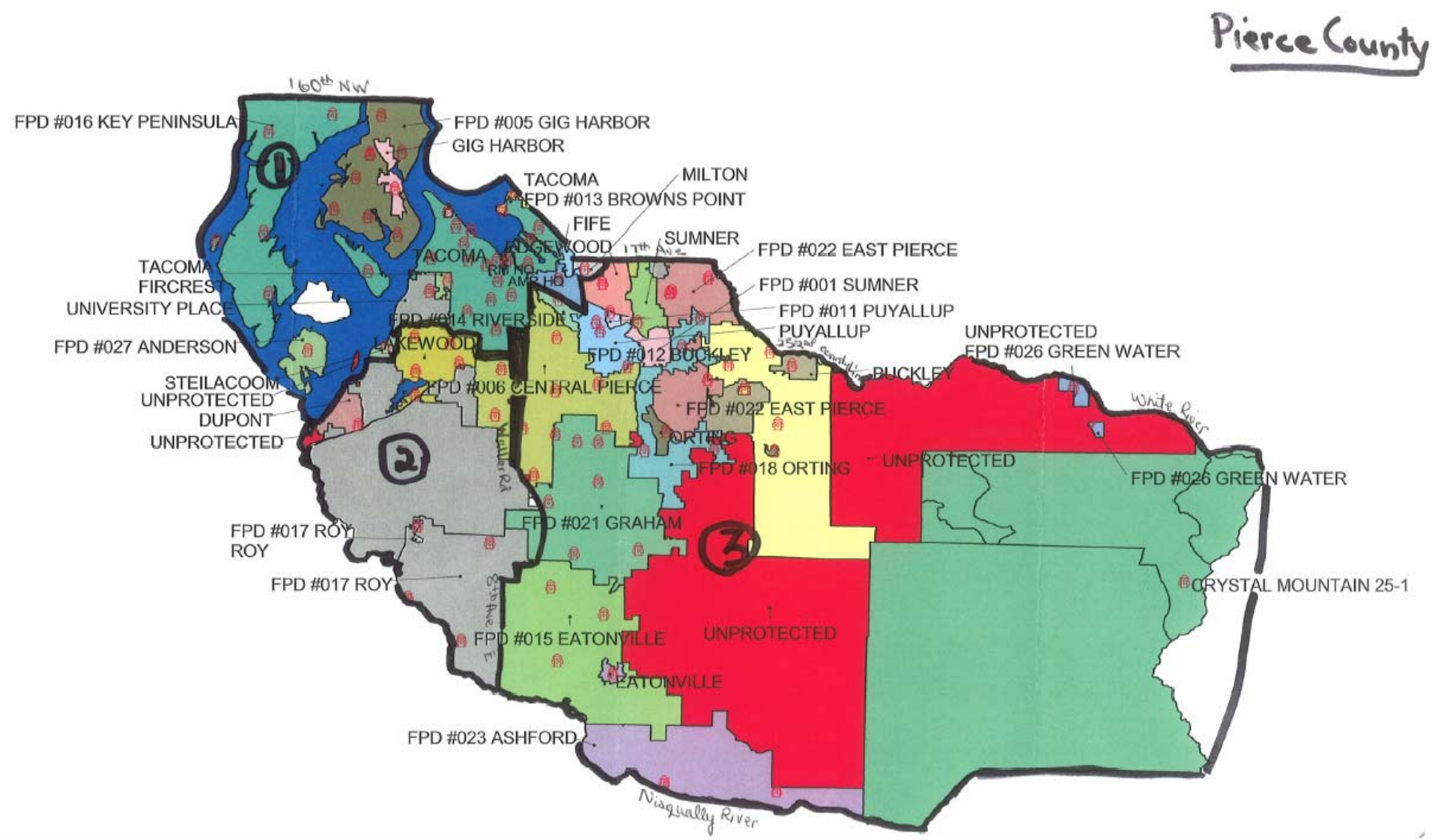
Projection: Lambert Conformal Conic; Datum: 1983 North American Datum; U.S.G.S. State Plane Zone 5626

LEWIS COUNTY
G.I.S.

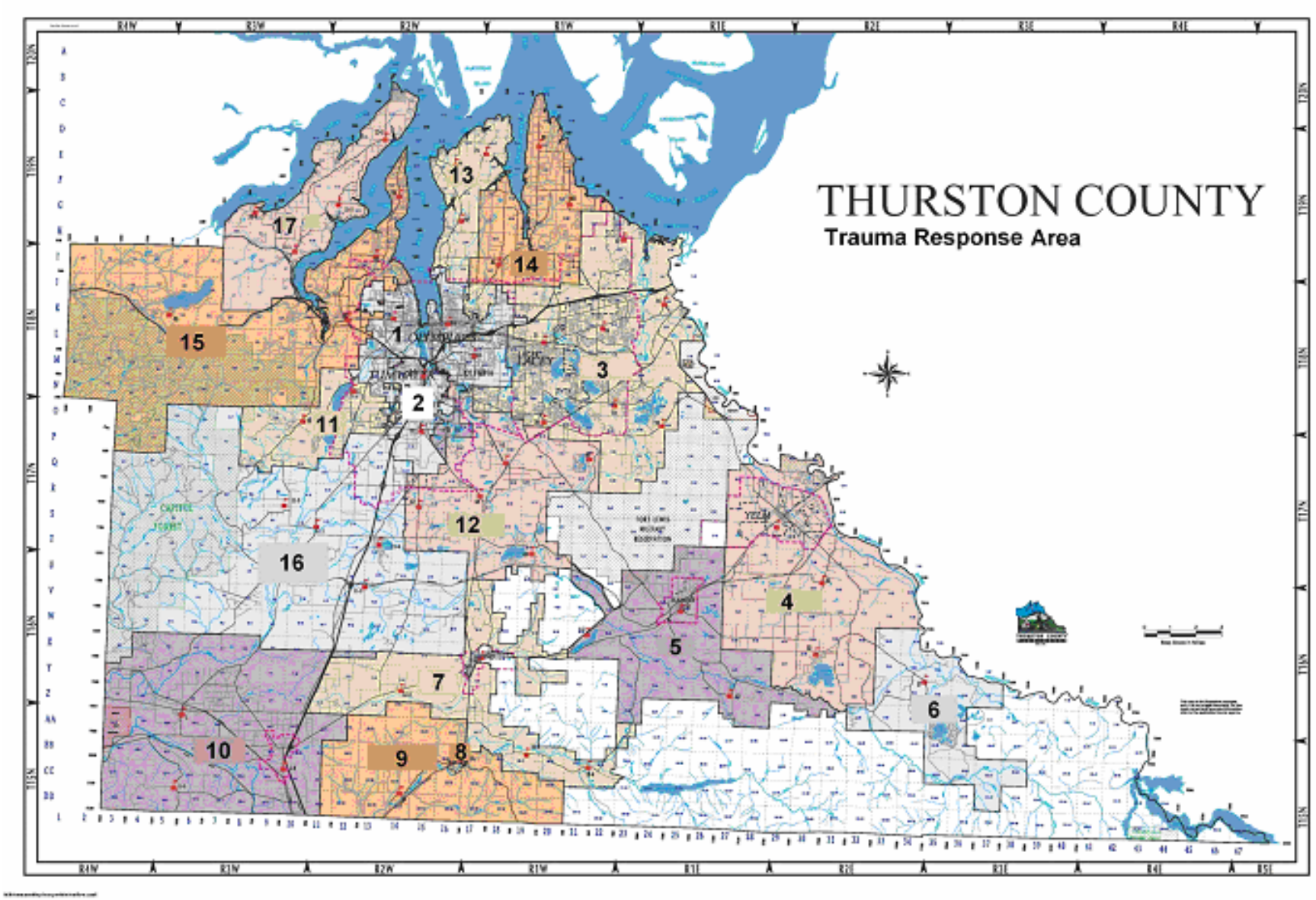
Pacific County Response Area Map



Pierce County Response Area Map



Thurston County Response Area Map



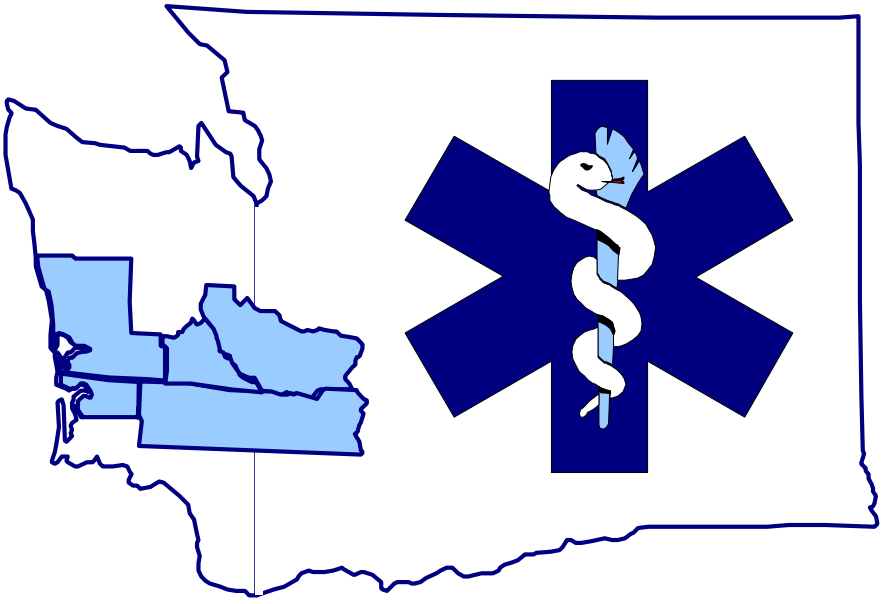
EMERGENCY MEDICAL SERVICES & TRAUMA CARE SYSTEM

FY 06-07

WEST REGION

Exhibit 2 - PCPs & County Operating Procedures

Reviewed April 2005.
No changes made to previously approved PCPs and COP



Who To Contact

Grays Harbor and N. Pacific Counties

Medical Program Director	Daniel Canfield, DO	(360) 533 6038
Grays Harbor County EMS Council	Jamie Golding	(360) 532 2067

Lewis County

Medical Program Director	Patrick O'Neill, MD	(360) 330 8516
Lewis County FPD #12	Mike Kytta, Assistant Chief	(360) 736 3975

Pierce County

Medical Program Director	Clark Waffle, MD	(253) 798 7722
EMS Coordinator	Norma Pancake	(253) 798 7722

Thurston County

Medical Program Director	Joe Pellicer, MD	(360) 704 2787
Thurston County Medic One	Steve Romines	(360) 704 2783

Department of Health

Office of Emergency Medical Services & Trauma System	Michael Lopez	(360) 236 2841

To request additional copies

West Region EMS & Trauma Care Council	(360) 705 9019
	(800) 546 5416

Patient Care Procedure #1

Medical Command at the Scene

OBJECTIVE

To define who is in medical command at the EMS scene, and to define line of command when multiple providing agencies respond.

PROCEDURE

The regional standard shall be for the incident command system to be used at all times. Per the incident command system, medical command will be designated by the incident commander. The medical commander should be the individual with the highest level medical certification who is empowered with local jurisdictional protocols.

Law enforcement will be responsible for overall scene security.

QUALITY ASSURANCE

Departure from this policy shall be reported to the MPD in the jurisdiction of the incident.

Patient Care Procedure #2

Responders & Response Times

OBJECTIVE

To geographically define urban, suburban, rural, & wilderness, and the required prehospital response time for those areas.

PROCEDURE

The regional standard for response times and responders shall be in accordance with current WAC 246-976-390 as follows:

Verified **aid services** shall meet the following minimum agency response times for response areas as defined by the department and identified in the approved regional plan:

(a) To urban response areas: Eight minutes or less, eighty percent of the time;
(b) To suburban response areas: Fifteen minutes or less, eighty percent of the time;
(c) To rural response areas: Forty-five minutes or less, eighty percent of the time;
(d) To wilderness response areas: As soon as possible.

Verified aid services shall provide **personnel** on each trauma response including:

(a) Aid service, basic life support: At least one individual, first responder or above;
(b) Aid service, intermediate life support: At least one IV/airway technician; or two individuals, one IV technician and one airway technician;
(c) Aid service, advanced life support: At least one paramedic.

Verified **ground ambulance** services shall meet the following minimum agency response times for response areas as defined by the department and identified in the approved regional plan:

(a) To urban response areas: Ten minutes or less, eighty percent of the time;
(b) To suburban response areas: Twenty minutes or less, eighty percent of the time;
(c) To rural response areas: Forty-five minutes or less, eighty percent of the time;
(d) To wilderness response areas: As soon as possible.

Patient Care Procedure # 2 (continued)

Verified ambulance services shall provide **personnel** on each trauma response including:

(a) Ambulance, basic life support: At least two certified individuals -- one EMT plus one first responder;
(b) Ambulance, intermediate life support:
    (i) One IV/airway technician, plus one EMT; or
    (ii) One IV technician and one airway technician, both of whom shall be in attendance in the patient compartment, plus a driver;
(c) Ambulance, paramedic: At least two certified individuals -- one paramedic and one EMT.

IMPLEMENTATION

Per WAC 246-976-430, each prehospital agency is responsible for collecting and submitting response time documentation within its response area through the State Trauma Registry.

QUALITY ASSURANCE

The response times and all agencies that do not meet the state standard will be reviewed by the West Region Quality Improvement Forum as reported by the State Trauma Registry. Response times will be tracked over a two-year period and the standards reevaluated based on input from the MPDs and responder agencies. Per WAC 246-976-440, the Department of Health shall provide registry reports to all providers that have submitted data.

Patient Care Procedure #3

Medical Control - Trauma Triage/Transport

OBJECTIVES

To define the anatomic, physiologic, and mechanistic parameters mandating trauma systems inclusion.

To define the anatomic, physiologic, and mechanistic parameters mandating designated trauma facility team activation.

PROCEDURES

Prehospital Trauma Triage-
Prehospital assessment of injured patients for triage into the trauma system and designated trauma facility team activation will be based on the current approved State of Washington Prehospital Trauma Triage (Destination) Procedures. Patients that meet trauma triage procedures criteria shall be transported to a designated facility as directed by the triage procedures (see Appendix B). Pediatric trauma patients will be transported to designated pediatric trauma facilities as directed by the trauma triage procedures (see Appendix B). Where appropriate the patient may be directed to the nearest appropriate designated trauma center for stabilization and physician evaluation. This may be done by ground or air.

Consider transport of unstable patients to nondesignated facilities capable of appropriately stabilizing the patient's medical needs prior to interfacility transfer of trauma patients to designated trauma facilities. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility.

County procedures that provide direction to field personnel regarding options when a potential destination facility is on divert are provided in Appendix C: County and Designated Trauma Facility Divert Policies.

Patient Care Procedure #3 (continued)

Medical Control-
Medical control will be contacted when possible for all trauma patients as defined above. When BLS/ALS responds, medical control contact should be made as early as possible by BLS/ALS ground personnel for the purpose of medical control and to confirm transport destination. Steps 1 and 2 require prehospital personnel to notify medical control and activate the Trauma System. Activation of the Trauma System in Step 3 is determined by medical control. Patients will be identified by applying orange trauma band to wrist or ankle. Data collection will be coordinated through band identification.

PHI or Equivalent-
Designated facilities will calculate PHI or an equivalent. Pediatric facilities will calculate pediatric trauma score.

IMPLEMENTATION

As of March 1, 1996, the region will utilize the resources of designated trauma facilities as they are designated within the region.

Providers will transport trauma activation patients according to the regional trauma facility designation plan as the plan is implemented.

QUALITY ASSURANCE

Per WAC 246-976-430, each prehospital agency is required to participate in the state data system by submitting documentation through the State Trauma Registry on all patients entered into the trauma system. The West Region Quality Improvement Forum will review trauma team activation and surgeon activation, as reported by the State Trauma Registry. This will include procedures and guidelines.

Medical controls will keep accurate recorded communications (log book or tape) for auditing as needed by local communication boards/local EMS councils and MPDs. Departure from this policy will be reported to the West Region Quality Improvement Forum.

Patient Care Procedure #4

Air Transport Procedure

OBJECTIVES

To define who may initiate the request for onscene emergency medical air transport services.

To define under what circumstances nonmedical personnel may request air transport onscene service.

To define medical control/receiving center communication and transport destination determination.

To reduce prehospital time for transport of trauma patients to receiving facility.

PROCEDURE

Any public safety personnel, medical or nonmedical, may call to request onscene air transport when it appears necessary and when prehospital response is not readily available. This call should be initiated through dispatch services. In areas where communications with local dispatch is not possible/available, direct contact with the air transport service is appropriate.

Air ambulance activation requires appropriate landing zones are available at or near the scene and at the receiving facility. Consider air transport when:
1) Hoisting is needed; 2) Helicopter transport will reduce the prehospital time to the greatest extent regarding the trauma triage procedures requirements.
Do not consider air transport when transport by helicopter to the receiving facility exceeds 30 minutes and exceeds the time for ground transport to another designated trauma or appropriate receiving facility. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility as needed. See Appendix D or most current Washington State list of designated trauma care service facilities. Activation of the helicopter does not predetermine the destination.

Steps 1 and 2 require prehospital personnel to notify medical control and activate the trauma system. Activation of the trauma system in Step 3 is determined by medical control.

When BLS/ALS responds, medical control contact should be made as early as possible by BLS/ALS ground personnel for the purpose of medical control and to confirm transport destination. The medical control should contact the receiving facility.

Patient Care Procedure #4 (continued)

When the use of a helicopter is believed by the field personnel to be the most expeditious and efficacious mode of transport, contact of local online medical control and activation of the trauma system will be concurrent to the activation of the helicopter.

Medical control will consider the following in confirming patient destination: location, ETA of helicopter, availability of ground transportation, proximity of other designated trauma receiving centers, their current capabilities and availability.

The air transport service is responsible for communicating to the initiating dispatch center the estimated time of arrival and significant updates as necessary. Air transport services are subject to their own protocols for appropriate activation. Air transport must contact the initiating dispatch center if unable to respond.

QUALITY ASSURANCE

The West Region Quality Improvement Forum will review reports by air transport agencies of launches including cancels, transports, and destinations, as provided by the State Trauma Registry.

Patient Care Procedure #5

Hospital Resource - Interfacility Transfer

OBJECTIVE

To establish recommendations for transport of patients from one designated trauma facility or undesignated medical facility to a designated trauma facility, consistent with established West Region guidelines.

PROCEDURE

All interfacility transfers will be in compliance with current OBRA/COBRA regulations.

Major trauma patients that were transported to undesignated trauma facilities for the purposes of stabilization and resuscitation must be transferred to a designated trauma facility (see Appendix D).

The transferring facility must make arrangements for appropriate level of care during transport.

The receiving center must accept the transfer prior to the patient's leaving the sending facility.

The receiving medical provider (physician) must accept the transfer prior to the patient's leaving the sending facility.

All appropriate documentation must accompany the patient to the receiving center.

The transferring physician's orders will be followed during transport as scope of provider care allows. Should the patient's condition change during transport, the sending physician, if readily available, or nearest medical control should be contacted for further orders.

Prehospital protocols from county of origin will be followed during the transport.

To the extent possible, a patient whose condition requires treatment at a higher level facility should be transferred to an appropriate facility within the region.

Patient Care Procedure # 5 (continued)

The destination medical center will be given the following information:
•Brief history
•Pertinent physical findings
•Summary of treatment
•Response to therapy and current condition

Further orders may be given by the receiving physician.

TRAINING

Hospital personnel will be oriented to regional transfer requirements and familiarized with OBRA requirements.

QUALITY ASSURANCE

The numbers of and reasons for interfacility transfers will be reviewed by the West Region Quality Improvement Forum as needed, based on data reports supplied by the State Trauma Registry. Inclusion indicators will be developed by the Forum in accordance with state and federal guidelines, as well as regional standards.

Patient Care Procedure #6

Prehospital Report Form

OBJECTIVE

To define the trauma information reporting requirement.

PROCEDURE

The regional standard for data reporting shall be consistent with WAC.

All critical patient information will be left at the patient's receiving facility. Completed prehospital forms will be submitted by prehospital providers to the receiving facility within two hours of patient arrival 95 percent of the time.

At a minimum, one copy of the prehospital report should be transported to the receiving facility, one copy should be retained by the prehospital provider, and one copy should be made available to the medical control or MPD for review.

These forms are to be used for gathering data for the State Trauma Registry.

Patient Care Procedure #7

EMS/Medical Control - Communications

OBJECTIVES

To define methods of expedient communication between prehospital personnel and medical control and receiving centers.

To define methods of communication between medical controls and regional designated trauma facilities and other facilities.

PROCEDURE

Communications between prehospital personnel and medical controls and receiving medical centers will utilize the most effective communication means to expedite patient information exchange.

IMPLEMENTATION

The State of Washington, the West Region EMS & Trauma Care Council, and regional designated trauma facilities will coordinate with prehospital and hospital EMS providers to create the most effective communication system based on the EMS provider's geographic and resource capabilities. Communication between the EMS prehospital provider and the receiving center can be direct (provider to center) or indirect (provider to medical control to designated trauma facility). Local medical control will be responsible for establishing communication procedures between the prehospital provider(s) and receiving hospital(s).

QUALITY ASSURANCE

Significant communication problems affecting patient care will be investigated by the provider agency and reported to the West Region Quality Improvement Forum for review. The agency will maintain communication equipment and training needed to communicate in accordance with WAC.

The West Region Quality Improvement Forum will address the issues of communication as needed.

Pierce County

PREHOSPITAL TRAUMA TRIAGE (DESTINATION) PROCEDURES

- Prehospital triage is based on the following 3 steps: Steps 1 and 2 require prehospital EMS personnel to notify medical control and activate the Trauma System. Activation of the Trauma System in Step 3 is determined by medical control**

STEP 1
ASSESS VITAL SIGNS & LEVEL OF CONSCIOUSNESS

- Systolic BP < 90°
- HR > 120°
- for pediatric (< 15y) pts. use BP < 90 or capillary refill > 2 sec.
- for pediatric (< 15y) pts. use HR < 60 or >120

Any of the above vital signs associated with signs and symptoms of shock

and/or

- Respiratory Rate <10 > 29 associated with evidence of distress

and/or

- Altered mental status

YES → 1. Take patient to the nearest Level I or Level II trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures.*

2. Apply "Trauma ID Band" to patient.

***Burns & amputations transported to Harborview Medical Center

**If prehospital personnel are unable to effectively manage airway, consider rendezvous with ALS, or intermediate stop at nearest facility capable of immediate definitive airway management.

NO ↓

STEP 2
ASSESS ANATOMY OF INJURY

- Penetrating injury of head, neck, torso, groin: OR
- Combination of burns ≥ 20% or involving face or airway; OR
- Amputation above wrist or ankle; OR
- Spinal cord injury; OR
- Flail chest; OR
- Two or more obvious proximal long bone fractures.

YES → (1. Take patient to the nearest Level I or Level II trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures.* 2. Apply "Trauma ID Band" to patient. *Burns & amputations transported to Harborview Medical Center)

NO ↓

STEP 3
ASSESS BIOMECHANICS OF INJURY AND OTHER RISK FACTORS

- Death of same car occupant; OR
- Ejection of patient from enclosed vehicle; OR
- Falls ≥ 20 feet; OR
- Pedestrian hit at ≥ 20 mph or thrown 15 feet
- High energy transfer situation
  - Rollover
  - Motorcycle, ATV bicycle accident
  - Extrication time of ≥ 20 minutes
- Extremes of age < 15 or > 60
- Hostile environment (extremes of heat or cold)
- Medical illness (such as COPD, CHF, renal failure etc.)
- Second/Third trimester pregnancy
- Gut feeling of medic

YES → CONTACT MEDICAL CONTROL FOR DESTINATION DECISION

YES → 1. Take patient to the nearest appropriate trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures.

2. Apply "Trauma ID Band" to patient.

NO ↓

NO ↓

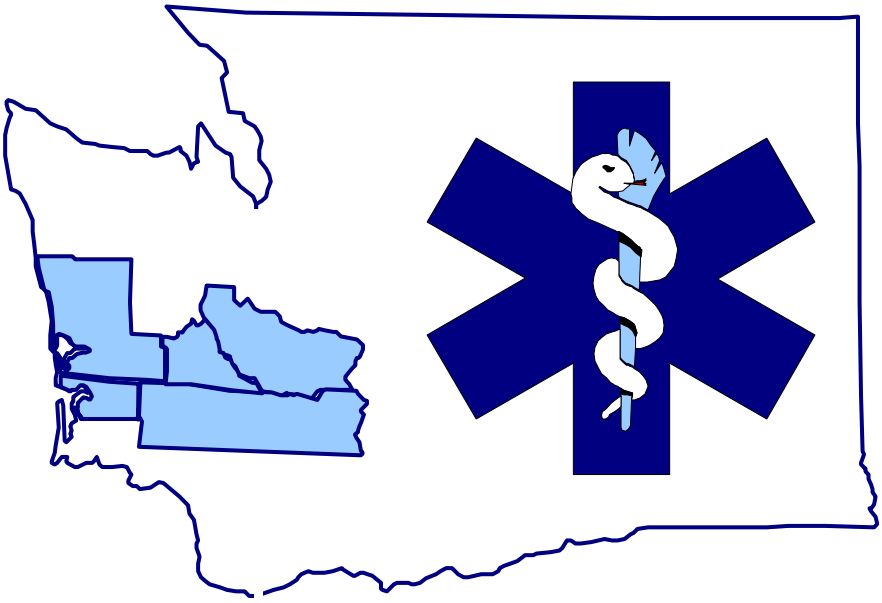
TRANSPORT PATIENT PER REGIONAL PATIENT CARE PROCEDURES

EMERGENCY MEDICAL SERVICES & TRAUMA CARE SYSTEM

FY 06-07

WEST REGION
BIENNIAL PLAN

Exhibit 3 - Council Operating Policies



I. System Access

OBJECTIVE

To define an expedient method of accessing trauma care system by victims, bystanders or public safety service.

PROCEDURE

The regional standard shall be for universal access to the trauma system, for having the nearest available response unit dispatched when needed, and for having enhanced 911 in place by 1998 in accordance with the state plan.

TRAINING

Dispatch training will be required to include emergency medical dispatch and trauma systems accessing. Ongoing training of dispatch personnel will occur. Region wide community education will focus on how to access the system when needed.

IMPLEMENTATION

The West Region will identify areas not currently serviced by the E911 system. The Council will support and work with the state E911 Office to realize the goal of regionwide E911 access.

QUALITY ASSURANCE

The region will gather and analyze data on dispatch information, response times, activation of trauma teams and any problems related to accessing the trauma system. This data may come from prehospital care forms, as well as other information systems that may be available to the region.

II. Communications

OBJECTIVES

To define a system for providing care instructions to the caller prior to arrival of prehospital care providers.

To define the system of interfacility communications.

PROCEDURE

The regional standard shall be for the dispatcher to provide priority based dispatch (or equivalent) instruction to the caller prior to prehospital provider arrival.

The regional standard shall be for all EMS receiving facilities to have a primary and at least one secondary method of interfacility communications, both landline and non-landline.

IMPLEMENTATION

Appropriate telephone aid instructions will be given to callers.

Current methods of communication between hospitals will be identified.

QUALITY ASSURANCE

Review of dispatch tapes will be completed by dispatch agencies as needed to ensure appropriate instructions were given.

All trauma and EMS receiving facilities will have written plans for interfacility communication, both landline and non-landline.

III. Dispatch

OBJECTIVE

To define a system for dispatching the closest appropriate level and number of prehospital care providers to the scene.

PROCEDURE

Appropriate dispatch will be:

1) Verified trauma services dispatched to trauma patients
2) Appropriate EMS services dispatched to EMS patients

IMPLEMENTATION

The closest trauma verified aid/and or verified ambulance service shall be dispatched to respond and/or transport to all known or suspected major trauma patients who meet (or are suspected to meet) Trauma Registry Inclusion Criteria [see Appendix B: Prehospital Trauma Triage (Destination) Procedures].

Trauma Verified Services shall proceed in an emergency mode to all suspected major trauma incidents until which time they have been advised of injury status of the patients involved. There will be communication between the onscene prehospital provider and medical control.

QUALITY ASSURANCE

Both hospital and prehospital providers will evaluate communication methods and dispatch, and report data as needed to the West Region Quality Improvement Forum for further evaluation and trend analysis.

IV. Prehospital Care: Mutual Aid

OBJECTIVES

To assure adequate EMS mutual aid within and across the West Region's boundaries. To develop a mechanism where EMS mutual aid requests are incorporated into dispatch, response, and medical incident command.

PROCEDURE

The regional standard shall be that all counties in the region have written mutual aid agreements.

IMPLEMENTATION

The county councils will identify those areas where mutual aid agreements are needed and provide assistance in attaining agreements between providers. Identification of mutual aid agreements will be made and available to all trauma care providers.

QUALITY ASSURANCE

The West Region Quality Improvement Forum will evaluate and review mutual aid agreements and the process as needed. Non responses or noncompliance with existing agreements shall be reported by the agency requesting assistance to the Forum for review.

V. Hospital Resource: Rehabilitation

OBJECTIVE

To assure that all major trauma patients have early access to and receive the appropriate physical medicine and rehabilitation services.

PROCEDURE

Rehabilitation services consultation will be available in each designated Level 1 – 3 Acute Trauma Facility.

Each designated acute trauma facility will have an individual(s) designated as a Rehab Trauma Coordinator. It is the responsibility of the Rehab Trauma Coordinator to make early contact with each major trauma patient and to facilitate the referral to and/or transfer to, if indicated, to the appropriate Level 1 or Level 2 designated rehabilitation facility services.

IMPLEMENTATION

The designated trauma rehabilitation providers in the region participate in the system by acquiring and maintaining designation by the Department of Health as a designated Rehabilitation Trauma Facility. Major trauma patients requiring inpatient rehabilitation services will be referred only to designated Rehabilitation Trauma Facilities.

TRAINING

Each designated rehab trauma facility will provide information to the acute care facilities to assure that the acute facilities are knowledgeable regarding access to rehab services. The Level 1 facility(ies) are required to provide outreach to the region regarding rehab issues.

QUALITY ASSURANCE

Quality assurance activities will be conducted under the direction of the West Region Quality Improvement Forum. The rehab Coordinators in the designated trauma facilities will serve on the West Region Quality Improvement Forum.

Any feedback received by the region regarding rehab services will be shared promptly with the facility identified for appropriate action.

RESOURCES/REFERENCES

- Heath Rehabilitation Center at Good Samaritan Hospital, Puyallup
- Providence St. Peter Hospital Rehabilitation Unit, Olympia
- Providence Centralia Hospital Rehabilitation Unit, Centralia
- St. Joseph Medical Center Rehabilitation Unit, Tacoma

VI. Prehospital Care: Patient Care Protocols

OBJECTIVE

To define all prehospital care protocols in the West Region.

PROCEDURE

There will be standardized treatment protocols developed with the region and accepted as the minimum standard by each county MPD. Prehospital providers will be able to provide the most efficient and optimal use of their level of training and resource regardless of political boundaries within the region.

IMPLEMENTATION

The Standards Committee, in collaboration with the county MPDs, will evaluate the regional prehospital protocols and standardize where possible and appropriate.

QUALITY ASSURANCE

The patient care protocols will be reevaluated by the Standards Committee annually and approved by the MPDs in the region.

VII. Prehospital Provider Equipment List

OBJECTIVE

To define the minimum equipment requirements for prehospital aid vehicles and ambulances.

PROCEDURE

The regional standard shall be for all licensed aid vehicles and ambulances to be minimally equipped per WAC 246-976-300. These include resuscitation equipment, basic equipment, contagious disease supplies, and medical, orthopedic, and extrication supplies. Pediatric supplies will also be present.

With concurrence of county MPDs, local councils, and regional council, the regional standard for equipment may exceed WAC requirements.

If a regional standard is to be exceeded by the region, that standard shall be identified to DOH/OEMTP. DOH/OEMTP shall notify the region if the standard is to be the responsibility of the state or region for implementation.

VIII. Quality Assessment And Improvement

OBJECTIVE

Identify the method to be used to assess and improve the quality of trauma care in the West Region.

PROCEDURES

Prehospital-
At least quarterly review of specific and appropriate components of the prehospital quality program will be completed under the direction of each county's MPD.

The following standard for quality assurance is intended as a minimal guideline only. All local entities are encouraged to use quality improvement techniques to continuously improve the outcome for those patients we serve.

Cases will be reviewed by the West Region Quality Improvement Forum per the plan, which will be updated as necessary.

Hospital-
A quality assurance forum composed of all MPDs, designated trauma facility representatives (nurse and doctor); ALS and BLS representatives from each county, medical control representatives, rehabilitation coordinators, county coroner/medical examiners, and a member from the MAST Committee will review all data analysis and observe trends. Representatives from nondesignated medical facilities, regional education and prevention representatives will be encouraged to participate in the West Region Quality Improvement Forum.

The West Region Quality Improvement Forum will report findings to the West Region Council for appropriate action.

IMPLEMENTATION

The West Region Quality Improvement Forum began meeting quarterly in January 1994. The Forum currently meets 5 times per year. These meetings are very well attended by those participants listed above and many other interested parties. A medical examiner/coroner report has been developed to analyze trauma deaths in the region by county. The forum agenda includes at least one morbidity and mortality case study each meeting. The State Trauma Registry data will enhance the abilities of regional quality improvement efforts to improve trauma patient care.

IX. Hospital/Prehospital EMS Personnel: Minimum Standards And Training

OBJECTIVES

To identify a minimum regional training standard for hospital and prehospital personnel.
To define designated trauma facility obligations to participate in EMS and trauma care provider training.

PROCEDURES

Non-Designated Hospital and Ambulance Personnel Standards-
In accordance with RCW 18.73.150, the minimum standards for any ambulance operated as such shall operate with sufficient qualified personnel for adequate patient care.

Verified Trauma Services and Designated Trauma Facilities

Training and Education-
All EMS providers of trauma verified ambulance services shall have PHTLS or equivalent trauma courses (WAC 246.976). This training shall accrue towards continuing medical education requirements for these providers.

Level I and II designated trauma facilities will be required to participate in prehospital trauma care training for EMS providers. In addition, the West Region strongly encourages level III and IV designated trauma facilities to participate also. All hospitals are encouraged to provide clinical setting and inhospital training. Regional training standards for hospital providers will be in accordance with WAC 246.976.

IMPLEMENTATION

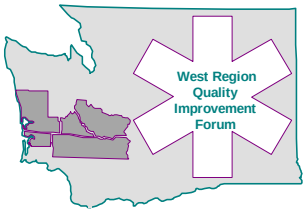
Perform annual regional training needs assessments.

Schedule adequate training to bring the region into compliance with the WAC, as stated above.

Identify the hospitals in the region which currently participate in prehospital trauma training.

QUALITY ASSURANCE

All prehospital trauma verified agencies and trauma care facilities will annually evaluate compliance with training requirements and report to the West Region Quality Improvement Forum.



WEST REGION

Exhibit 4 - Quality Improvement Plan

Mission Statement

Continuously strive to optimize
Trauma/EMS patient care and outcome.

Approved by DOH: May 12, 1997
Revised by QIF on: December 12, 2002

Administrative Support Provided by
West Region Emergency Medical Services & Trauma Care Council, Inc.
Proudly Serving Grays Harbor, Lewis, N. Pacific, Pierce and Thurston Counties
2407 Pacific Ave SE, Suite B, Olympia, WA 98501
360-705-9019 • 1-800-546-5416 • FAX: 360-705-9676 • www.wrems.com

WEST REGION QUALITY IMPROVEMENT PLAN

Mission Statement

Continuously strive to optimize Trauma/EMS patient care and outcome.

GOALS: IMPROVE CARE, NOT JUST MONITOR OUTCOMES

1. Collect Accurate, Timely Data

An essential prerequisite to effective quality improvement.

1.a. Include Prehospital Care Analysis

True systems review requires more than hospital-alone quality review. All prehospital providers within the region should be included in the QI process.

2. Analyze Patterns and Trends of Regional Trauma Care

Compare similarities and differences between West Region and other regional, state and national models.

2.a Assess Patient Flow Patterns

A special concern of West Region is trauma patient flow patterns as well as inter-facility transfers and methods of transport. Ongoing monitoring will be required to provide data for consideration of additional (or fewer) designated trauma centers.

2.b Compare Similar Hospital/Agency Outcomes

Case review requires objective comparisons with similar institutions within the region, state or nationally. In addition, a "benchmark" or "gold standard" to which comparisons can be made, regardless of institutional status, is required.

2.c Analyze Individual Cases of Trauma Care

Highlighting the trends and patterns with individual case review. This will provide a specific focus for improvements and changes, as well as affording the opportunity to discuss individual cases.

3. Action Plan/Loop Closure

3.a West Region EMS Council

Provide communication on patterns and trends of regional trauma care to the West Region Council or appropriate agency.

3.b Opportunities for Improvement

Recommend opportunities for improvement to the appropriate training or prevention committee of the West Region Council.

3.c Loop Closure

Cases sent to the QIF for review and recommendation require follow-up with action taken at the next meeting.

PRINCIPLES

- **Trauma Center Leadership**
  As described in WAC 246-976-910 (2) and RCW 70.168.090 (2): Levels II, and III trauma care facilities shall establish and participate in regional EMS/TC systems quality improvement programs.

- **System Analysis**
  This is intended to be a process for continuous quality improvement of the regional system of trauma care throughout the age continuum. It is not intended to duplicate or supplant quality improvement programs of the individual hospitals, rehabilitation units, or prehospital agencies involved in regional trauma care. The state Trauma Registry will provide accurate data to assess regional performance as well as individual provider/agency performance.

- **Confidential Case Review & Education**
  Effective identification, analysis and correction of problems requires objective review by qualified, appropriate members of trauma care programs, protected by a process which ensures confidentiality. The approach used by the QIF will be standard case review profiling and issue for education and/or process improvement.

PROCESS

MEMBERSHIP

As stated in WAC 246-976-910(3):
The regional quality improvement program: Shall include at least one member of each designated facility's medical staff, an EMS provider, and a member of the EMS/TC region.

And WAC 246-976-910(4):
The regional quality improvement program shall invite the MPD and all other health care providers and facilities providing trauma care in the region, including non-designated facilities and non-verified prehospital services, to participate in the regional trauma quality improvement program.

In accordance with the above administrative code, the West Region EMS/TC QIF membership will be:

Voting Members:
Trauma Medical Director from each designated trauma and trauma rehabilitation center
Trauma Nurse Coordinator from each designated trauma and trauma rehabilitation center
Medical Program Director (MPD) from each county - total 4
EMS provider - 3 from each county (2 prehospital and 1 private)
CQI representative – 1 prehospital and 1 hospital from (level II and/or III) each county
Regional EMS Council Chair
Regional injury prevention representative: 1 pediatric and 1 adult

**Any of the above members may be replaced by an official designee from the represented facility or agency.*

Non-voting Members:
Emergency Department Directors (clinical and medical)
ICU (Critical Care) Department Directors (clinical and medical)
State DOH staff
Appropriate medical specialists as needed and determined by chairperson
Non-designated facility representatives
Coroner/Medical Examiner from each county
EMS Coordinator/Director from each county
Regional Council staff member
*Airlift Northwest
*Dispatch center representative from each county
*Out of region member (required with joint designation)

**As appropriate for QA purposes*

Quorum: A quorum shall consist of a minimum of 10 voting members at the beginning of the meeting and will continue as long as 6 or more voting members remain.

- **Confidentiality**

  Actions of the QIF are confidential as provided in WAC 246-976-910 (5)(e)(f)(g)(h) and protected by RCW 43.70.510 and chapters 18.71, 18.73, and 70.168. *See Attachment A.* A written plan for confidentiality is required. *See Attachment B.* Notification in writing of the confidentiality of each meeting is required. Information identifying individual patients cannot be publicly disclosed without patient consent.

- **Regional QA meetings**

  - Frequency: Quarterly
  - 3 hours in length
  - Chairperson and 2 Vice Chairs: 3 year position elected by the majority of voting members (preferred structure: Chair = MD)
  - Review of Plan goals every 3 years with change in Chairperson

- **Four components to meeting**

  - Review of regional data and trends
  - Performance Improvement (PI) Project Presentation
  - Focused case(s) review with directed discussion
  - Next QIF meeting goals and targets
  - Yearly process/injury focus will be identified at the last meeting of year

- **Summary Conclusions and Reporting**

  The Chairperson is responsible for providing summary conclusions of discussions. Provisions must be provided for feedback to the Department of Health and the regional council on identified EMS/TC issues and concerns.

DETAILS

Component 1: Review of regional data and trends

The state Trauma Registry shall provide a routine Trauma Summary Report (as defined) distributed with the agenda in advance. These reports are standardized, emphasizing the state and regional trauma system.

- The state Trauma Registry shall provide a focused report on issues/filters as requested

Component 2: Performance Improvement Project Presentation

Presentation will include following points:

- Problem identification
- Process changes
- Implementation process
- Evaluation
    - Lessons learned

Component 3: Focused cases reviews

Designated agencies present injury or process specific case reviews as assigned by the committee. A minimum of two cases will be presented, not to exceed 30 minutes and include:

- Topics from case for discussions
- Continuum of care from dispatch through rehabilitation
- Major players involved be present or available for questions and discussion
- Audio-visual aids
- Lessons learned
- Suggested template for case review (See Attachment C)

COMPONENT 4: IDENTIFICATION OF NEXT QUARTER'S MEETING GOALS AND TARGETS

ATTACHMENT A

WEST REGION QUALITY IMPROVEMENT FORUM

QI FORUM MEMBERS AND GUESTS
CONFIDENTIALITY AGREEMENT
in accordance with RCW 70.168.090(3) and (4)

The undersigned attendees of the QI Forum meeting held (date), agree to hold in strict confidence all information, data, documentation, and discussions resulting from this meeting, and subsequently documented in meeting minutes. No information will be disclosed to parties outside this QI Forum, except as agreed to by the attendees for the purposes of follow-up, resolution or systems design changes. Failure to observe this agreement will result in dismissal from the Forum and possible personal liability.

First Name	Last Name	Title	Job Title	Agency	Signature

ATTACHMENT B

West Region Quality Improvement Plan

Confidentiality and Exemption from Discoverability Policy and Procedures

June 1997

Policy

It is the intention of the West Region Quality Improvement Forum (QIF) to use the information gathered to support clinical research and improve patient care through improved systems performance. It is necessary that providers have protection from discoverability and possible liability to reach that end.

Pledge of Confidentiality

All attendees of the QIF will sign a pledge of confidentiality which will also act as a record of attendance. At each meeting the pledge of confidentiality will be read into the minutes. (See Attachment A).

Documentation

Patient records will be identified by the unique Trauma Registry identifier. Patient information cannot be publicly disclosed without written permission of the patient or guardian.

All QIF handouts shall be labeled "Confidential QI Document/Privilege Information/Not Authorized for Distribution." All confidential documents will be collected at the end of the meeting, and all copies will be destroyed following the meeting. One permanent copy will be kept in a locked cabinet.

Minutes

Minutes from QIF meetings will be prepared by the West Region EMS staff. Minutes will be reviewed and approved by the members. One copy of the minutes will be kept for the purpose of record by the West Region EMS, and its staff will be responsible for collecting and destroying all documents following the meeting. Retention schedule for minutes will be 4 years. The one permanent copy will be kept in a locked cabinet. Any case specific information presented during QIF meetings will be held in strict confidence among those attending the meeting. All identifying references to specific cases will be omitted from meeting minutes.

Reports

A report will be generated to summarize significant findings of the materials reviewed in the QIF meeting. The summary report will be modified to scrub information that might identify individuals or agencies involved in the QI review. Names, dates, times and situations may be modified to prevent loss of confidentiality while communicating intent of the finding(s). The QIF Chair will approve the summary report before it is released external to the QIF.

Access to Information

All members of the QIF, and those who have been invited to attend by members of the forum, have access to view or discuss patient, provider, and systems information when the patient and the provider's identifying information has been obscured. It is the obligation of the attendees to keep all information confidential and to protect it against unauthorized intrusion, corruption, and damage.

ATTACHMENT C

TEMPLATE FOR CASE REVIEWS

I. WRQIF Case Review

- *Name of presenter*
- *Name of agencies represented*
- *Date*

II. Topic

- *Question or issue to be addressed with this case review*

Scene/Background Information

IV. EMS Findings/Interventions

- *Description of Pt*
- *Vital Signs*
- *Interventions*

V. ED Interventions/Findings

- *Vital Signs*
- *Interventions*
- *Findings*
- *Injury List*
- *Consults*
- *Pt Disposition*

VI. Hospital Course

- *Length of Stay*
- *Surgeries*
- *Other Injuries/Procedures Done*
- *Cost*

VII. Outcome

- *Discharge Status*
- *Current Update on Pt Outcome*